PATIENT INFORMATION

DATE _____

NAME _____
LAST FIRST MIDDLE HOME/CELL PHONE #

ADDRESS _____
CITY ZIP CODE

IN THE EVENT OF AN EMERGENCY, PLEASE CONTACT: _____ PHONE NUMBER _____

OCCUPATION _____ EMPLOYER _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

MARITAL STATUS _____ SPOUSE'S NAME _____ OCCUPATION _____

PERSON RESPONSIBLE FOR ACCOUNT _____

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED IN OUR OFFICE PREVIOUSLY? _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

WHY DID YOU CHOOSE OUR OFFICE? _____

EMAIL ADDRESS _____

INSURANCE INFORMATION

DENTAL INSURANCE YES NO _____

GROUP NAME _____ GROUP # _____

NAME OF INSURED _____ INSURED'S SOCIAL SECURITY NUMBER _____

INSURED'S EMPLOYER _____ INSURED'S BIRTH DATE _____

SECONDARY INSURANCE YES NO _____

GROUP NAME _____ GROUP # _____

NAME OF INSURED _____ INSURED'S SOCIAL SECURITY NUMBER _____

INSURED'S EMPLOYER _____ INSURED'S BIRTH DATE _____

I AUTHORIZE THIS DENTAL OFFICE TO TREAT MY MINOR CHILD - INCLUDING FILLINGS, X-RAYS, FLOURIDE AS NECESSARY. ANY CHANGES IN THIS AUTHORIZATION MUST BE BROUGHT TO THE ATTENTION OF THE OFFICE STAFF. PARENT REQUESTING TREATMENT FOR CHILD IN OFFICE IS RESPONSIBLE FOR CHARGES TO OFFICE DIRECTLY.

SIGNATURE _____ RELATIONSHIP _____

MEDICAL HISTORY

GENERAL HEALTH: EXCELLENT GOOD FAIR POOR

PHYSICIAN NAME: _____

PHYSICIAN ADDRESS _____ TELEPHONE NUMBER _____

LAST COMPLETE PHYSICAL _____

ARE YOU BEING TREATED BY A PHYSICIAN AT THIS TIME? _____

IF YES, PLEASE EXPLAIN _____

ARE YOU TAKING ANY MEDICATIONS NOW? FOR WHAT PURPOSE: _____

ARE YOU TAKING BIRTH CONTROL PILLS? YES ☐ NO ☐ _____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING: _____

DO YOU HAVE NOW OR HAVE YOU EVER HAD:

	YES	NO
Heart Murmur		
Congenital Heart Defect		
Rheumatic Fever		
Angina		
Heart Attack		
Heart Disease		
Stroke		
Abnormal Blood Pressure		
Blood Diseases		
Sinus Trouble		
Asthma		
Hay Fever		
Emphysema		
Cancer		
Prosthesis		

	YES	NO
Persistant Cough		
Tuberculosis		
Other Respiratory Problems		
Jaundice		
Hepatitis		
Ulcers		
Arthritis		
Diabetes		
Epilepsy		
Glaucoma		
Thyroid Problem		
Blood Transfusion		
Alcoholism		
HIV Positive		

Do you smoke? Yes ☐ No ☐
How much do you smoke? _____
Do you use chewing tobacco? _____
Have you ever been treated (other than diagnostic) with x-ray? Yes ☐ No ☐
Are you allergic to any of the following: Penicillin ☐ Coedine ☐ Asprin ☐ Local Anesthetics ☐
Are there any other medications that you may be allergic to: _____
Are you subject to prolonged bleeding? Yes ☐ No ☐
Are you pregnant? Yes ☐ No ☐

DENTAL HISTORY

How would you rate your current level of dental health? Excellent ☐ Good ☐ Fair ☐ Poor ☐
On a scale of 1-10 (10 being the highest), what priority do you rate your teeth? _____
Do you expect to keep your teeth for your lifetime? Yes ☐ No ☐
Are you satisfied with the appearance of your teeth? Yes ☐ No ☐ If no, please explain _____
_____
Have you ever had a bad experience in a dental office? Yes ☐ No ☐ If yes, please explain _____
_____
Were you satisfied with your previous dentist? Yes ☐ No ☐ If no, please expalin _____
_____
What expectations do you have from our office? _____
_____
Are you afraid of receiving dental treatment? Yes ☐ No ☐ How can we help overcome your fears? _____
_____
Do you have difficulty chewing? Yes ☐ No ☐ Please explain _____
_____
Are any of your teeth sensitive to: Cold ☐ Hot ☐ Chewing ☐
Are you subject to frequent headaches?
Do you hear clicking or cracking in the joints in front of your ears? Yes ☐ No ☐
Any pain or tenderness in the joints in front of your ears? Yes ☐ No ☐
Does your jaw lock open or closed? Yes ☐ No ☐

SIGNATURE _____

ANY CHANGES IN YOUR MEDICAL HISTORY?

YES / NO	DATE	SIGNATURE
YES / NO	DATE	SIGNATURE
YES / NO	DATE	SIGNATURE
YES / NO	DATE	SIGNATURE
YES / NO	DATE	SIGNATURE
YES / NO	DATE	SIGNATURE
YES / NO	DATE	SIGNATURE
YES / NO	DATE	SIGNATURE
YES / NO	DATE	SIGNATURE