☐ Male ☐ Female

Patient Information

Date:

Patient Name: _____ email: _____
Last First MI

Birthdate:_____/_____/_____ ☐ Married ☐ Single ☐ Minor Social Security: _____

Phone (Home): (_____)_____ (Cell): (_____)_____ (Work): (_____)_____

Address: _____
Street Apartment # City State Zip Code

Patient's Employer: _____ Occupation: _____

Person to contact in case of emergency: _____ Relationship: _____ Phone: (_____)_____

If you are completing this form for another person, what is your relationship to that person? Name: _____ Relationship: _____

Whom may we thank for referring you to our practice? _____

Responsible Party Information

If minor please complete

If self, please check this BOX ☐

Name: _____ Relationship: _____ Driver's License: _____

☐Male ☐ Female Birthdate: _____/_____/_____ ☐ Married ☐ Single ☐ Other Social Security #: _____

Address if different: _____
Street Apartment # City State Zip Code

Phone (Home): (_____)_____ (Cell): (_____)_____ (Work): (_____)_____

Insurance Information

Primary Dental Coverage Information

If you do not have primary coverage, please check this BOX ☐

Name of Subscriber: _____ Subscriber's Birth Date: ____/____/____ Is Subscriber a patient? ☐ Yes ☐ No
Last First MI

Social Security/ ID #: _____ Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Address if different: _____
Street City State Zip Code

Insurance Plan Name: _____ ID# _____ Phone: _____

Claims Address: _____

Subscriber's Employer Name: _____ Occupation _____ Phone: _____

Employers Address: _____
Street City State Zip Code

Secondary Dental Coverage Information

If you do not have secondary coverage, please check this BOX ☐

Name of Subscriber: _____ Subscriber's Birth Date: ____/____/____ Is Subscriber a patient? ☐ Yes ☐ No
Last First MI

Social Security/ ID #: _____ Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Address if different: _____
Street City State Zip Code

Insurance Plan Name: _____ ID# _____ Phone: _____

Claims Address: _____

Subscriber's Employer Name: _____ Occupation _____ Phone: _____

Employers Address: _____
Street City State Zip Code

Dental History

Please answer each question by circling Yes or No.

Do you have a specific dental problem or chief complaint? Describe: _____ Yes No

Do you have dental examinations on a routine basis? When was your last dental visit? _____ Yes No

Do you think you have gum disease? _____ Yes No

Do you brush and floss on a routine basis? How often? _____ Yes No

Do your gums ever bleed? Describe: _____ Yes No

Do you like your smile? Why: _____ Yes No

Do you want to keep your remaining teeth? _____ Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No

Have your past experience in a dental office been positive? _____ Yes No

Name of previous dentist: _____ Date of last full mouth x-rays serious: _____/____/____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Date: _____/_____/_____ Signature: _____
(If patient is a minor, include printed name and signature of parent or legal guardian)

Health Information

Patient Name: _____ Date:_____
Last First MI

Please answer each question by checking the appropriate box or circling Yes or No.

1. Are you in good health?..... Yes No
2. Date of last physical examination:_____
3. Are you now under the care of a physician?..... Yes No
   If yes, what is the condition being treated?_____
   Doctor's name:_____ Telephone #:_____
4. Have you ever had any serious illness or operation or been hospitalized?..... Yes No
   Please explain:_____
5. Are you taking any medication?. Yes NO…If Yes, please list medications and dosage_____
   _____
6. Are you using any recreational drugs (e.g., marijuana, cocaine) or controlled substances?..... Yes No
   If yes, what? _____
7. Have you ever been pre-medicated with antibiotics for your dental treatment? …….. Yes No
8. Are you sensitive or allergic to any drugs or materials? ☐ Penicillin ☐ Tetracycline ☐ Erythromycin
   ☐ **Aspirin** ☐ **Codeine** ☐ **Latex** ☐ **Other If Other, please list:**_____ Yes No
9. Do you have or have you had any of the following: **Please check "Y" for Yes or "N" for No --- answer all conditions:**

☐Y ☐N AIDS	☐Y ☐N Cortisone Medicine	☐Y ☐N Hemophilia	☐Y ☐N Respiratory Disease
☐Y ☐N Allergies or Hives	☐Y ☐N Diabetes	☐Y ☐N Hepatitis or jaundice	☐Y ☐N Rheumatic Fever
☐Y ☐N Allergies to Metals	☐Y ☐N Difficulty in Swallowing	☐Y ☐N Herpes	☐Y ☐N Rheumatism
☐Y ☐N Anemia	☐Y ☐N Drug addiction	☐Y ☐N High Blood Pressure	☐Y ☐N Sickle Cell Disease
☐Y ☐N Angina Pectoris	☐Y ☐N Emphysema	☐Y ☐N HIV Positive	☐Y ☐N Sinus Trouble
☐Y ☐N Arthritis	☐Y ☐N Epilepsy or Seizures	☐Y ☐N Joint Replacement	☐Y ☐N Stomach Ulcers
☐Y ☐N Artificial Heart Valve	☐Y ☐N Excessive Bleeding	☐Y ☐N Kidney Disease	☐Y ☐N Stroke
☐Y ☐N Asthma	☐Y ☐N Fainting Spells/Seizures	☐Y ☐N Liver Disease	☐Y ☐N TMJ
☐Y ☐N Blood Disease	☐Y ☐N Glaucoma	☐Y ☐N Mental Disorders	☐Y ☐N Thyroid Disease
☐Y ☐N Blood Transfusion	☐Y ☐N Hay Fever	☐Y ☐N Mitral Valve Prolapse	☐Y ☐N Tonsillitis
☐Y ☐N Bruise Easily	☐Y ☐N Head Injuries	☐Y ☐N Nervous Disorders	☐Y ☐N Tuberculosis
☐Y ☐N Chemotherapy	☐Y ☐N Heart Ailments/Attack	☐Y ☐N Pain in Jaw Joints	☐Y ☐N Tumors or Growths
☐Y ☐N Cold Sores	☐Y ☐N Heart Failure	☐Y ☐N Psychiatric Treatment	☐Y ☐N Venereal Disease
☐Y ☐N Congenital Heart Lesions	☐Y ☐N Heart Murmur	☐Y ☐N Radiation Treatment	

10. Do you wear a cardiac pacemaker, or have you had heart surgery? If yes, please explain:_____ Yes No
11. Do you smoke, chew, use snuff or any other forms of tobacco?..... ... Yes No
    ☐Cigarettes ☐ Cigars ☐ Chew ☐ Snuff ☐ Other If yes, how much?_____
12. Do you consume alcoholic beverages? If yes, how much?_____..... Yes No
13. Have you ever taken the drug "Fen-Phen" or "Redox"? …….. Yes No
14. Are you or have you ever taken Bisphosphonates for osteoporosis, multiple myeloma or other cancers
    (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa? ……..... Yes No
15. Are you pregnant? If yes, how many months_____..... N/A Yes No
16. Do you have any problems associated with your menstrual period?..... N/A Yes No
17. Do you take birth control pills?..... N/A Yes No
18. Is there anything we should know about your health that is not mentioned above?..... Yes No
    Please explain: _____

1st CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Date:_____ Signature: _____
(If the patient is a minor, include printed name and signature of parent or legal guardian.)

2nd Update-Since your last visit

1. Have you seen a medical doctor?.....Yes No
2. Have you had a change in any medication? Yes No
3. Have you had a change in any medical condition or had surgery?.....Yes No
If yes please explain: _____
_____
Date:_____Signature_____

3rd Update-Since your last visit

1. Have you seen a medical doctor?.....Yes No
2. Have you had a change in any medication? Yes No
3. Have you had a change in any medical condition or had surgery?.....Yes No
If yes please explain: _____
_____
Date:_____Signature_____

4th Update-Since your last visit

1. Have you seen a medical doctor?_.....Yes No
2. Have you had a change in any medication? Yes No
3. Have you had a change in any medical condition or had surgery?.....Yes No
If yes please explain:_____
_____
Date:_____Signature_____

DO NOT WRITE IN THIS SPACE

	Date	B.P	PULSE	REVIEWED BY	DENTIST'S COMMENTS
1ST	___/___/___	___/___	_____	_____	_____
2nd	___/___/___	___/___	_____	_____	_____
3RD	___/___/___	___/___	_____	_____	_____
4TH	___/___/___	___/___	_____	_____	_____