Date: _____

PATIENT INFORMATION

Name: Last First Middle Preferred Date of Birth:

Home Phone: ( ) Work Phone: ( ) Cell Phone: ( ) E-MAIL: ☐ Male ☐ Female ☐ Child ☐ Married ☐ Single ☐ Other

Address: Street City State Zip Code

Employer: Occupation: SSN: How did you hear about our practice?

Emergency Contact: Name Relationship: Home Phone: ( ) Work Phone: ( )

HEALTH INFORMATION

Physician Name: City/ State: Phone: ( )

Date of last visit: Reason For visit:

Have you been admitted to a hospital or needed emergency care during the past 5 years? ☐ Yes ☐ No
If yes, please explain:

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain:

Do you have any current health problems? ☐ Yes ☐ No
If yes, please explain:

Do you, or have used, any form of tobacco? ☐ Yes ☐ No

For women: Are you, or could you be pregnant? ☐ Yes ☐ No

Are you currently taking a bisphosphonate medication for osteoporosis? ☐ Yes ☐ No

Are you allergic to, or had an adverse reaction for any of the following? (please circle)
LATEX ASPIRIN PENICILLIN ERYTHROMYCIN

Please list any other medication or substance that you are allergic to:

Are you currently taking any medications? If yes, please list below:

Medication	Dosage	Reason

Have you had or been treated by a physician for:

Damaged Heart Valves, Mitral Valve Prolapse, or Artificial Heart Valves? ☐ Yes ☐ No

Rheumatic Fever, Rheumatic Heart Disease, or Congenital Heart Problems? ☐ Yes ☐ No

Have you ever been advised to pre-medicate prior to dental treatment? ☐ Yes ☐ No

Artificial Joints/Replacements? ☐ Yes ☐ No

High Blood Pressure? ☐ Yes ☐ No

Cancer, Tumors, or Growths? ☐ Yes ☐ No

Hepatitis, TB, AIDS, AIDS related conditions, or tested HIV positive? ☐ Yes ☐ No

Diabetes? ☐ Yes ☐ No

Circle any conditions listed below that you have, or have had:

Alcoholism	Chemotherapy	Hepatitis A	Radiation Therapy
Anemia	Emphysema	Hepatitis B	Sinus Problems
Angina	Epilepsy/Seizures	Kidney Disease	Stroke
Arthritis	Fainting	Liver Disease	Thyroid Disease
Asthma	Glaucoma	Mental Disorders	Tuberculosis (TB)
Blood Disorder	Hay Fever	Pacemaker	Ulcers

Provider notes: _____

DENTAL INFORMATION

When was your last dental visit?	Name of Previous Dentist:
What is your main dental concern?	City/ State: Phone: ( )

Have you had dental x-rays taken within the past 2 years? ☐ Yes ☐ No ☐ Don't Know

Are your teeth sensitive to hot, cold, sweets, or biting pressure? ☐ Yes ☐ No ☐ Don't Know

Would you like your smile to look better or different? ☐ Yes ☐ No ☐ Don't Know

Are you aware of grinding or clenching your teeth? ☐ Yes ☐ No ☐ Don't Know

Do you have pain in your jaw joints or have frequent headaches? ☐ Yes ☐ No ☐ Don't Know

Have you ever had any injuries to your teeth or jaws? ☐ Yes ☐ No ☐ Don't Know

Have you ever had braces on your teeth? ☐ Yes ☐ No ☐ Don't Know

Have you ever been treated for gum disease or had periodontal surgery? ☐ Yes ☐ No ☐ Don't Know

Are you anxious or fearful about dental visits? ☐ Yes ☐ No ☐ Don't Know

If yes, please explain:

How often do you brush? ..... Manual or Electric How often do you use dental floss? .....

Provider notes: _____

_____

INSURANCE INFORMATION

Name of Insured: Last First Middle				Insured's Birth Date:
SSN #:	ID #:	Group #:	Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other	
Insured's Address: Street	Apt. #	City	State	Zip Code
Insured's Employer Name:		Insurance Company Name:		Phone: ( )
Insured's Employer Address: Street	Apt. #	Insurance Company Address: Street		
City	State Zip Code	City	State	Zip Code

CONSENT FOR SERVICES

- To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health I will inform the doctor at the next appointment.
- I authorize the release of any medical information necessary to process claims.
- I understand that I am personally responsible for all professional fees at the time service is rendered. In the event of default, the undersigned agrees to pay all costs of collection including any reasonable attorney's fees and court costs.

_____ Date: _____

Signature of patient, parent or guardian

_____ Relationship: _____

If parent/guardian, please print name