



PATIENT INFORMATION

Date _____
Patient Name _____ SSN# _____ Date of Birth _____
Address _____ City/State _____ Zip _____
Employer _____ Phone _____ Occupation _____ Drivers License# _____
Sex M F Marital Status: Married Single Minor Other _____ Whom may we thank for referring? _____
Spouse's Name _____ E-mail address _____

RESPONSIBLE PARTY INFORMATION (if different from Patient)

Spouse Parent Guardian
Name _____ SSN# _____ Date of Birth _____ Driver License # _____
Address _____ City/State _____ Zip _____
Employer _____ Phone _____ Occupation _____

DENTAL INSURANCE INFORMATION

PLEASE ALLOW US TO COPY YOUR INSURANCE CARDS AND DRIVERS LICENSE

Subscriber's Name _____ Relationship to Patient _____
Date of Birth _____ SS# _____ Insurance Member ID# _____
Insurance Co. _____ Group # _____ Phone: _____

PHONE NUMBERS

Home _____ Work _____ Ext. _____ Cell _____
Spouse's Work _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship to Patient _____
Home _____ Work _____ Ext. _____ Cell _____

(Specify someone who does not live in your household)

Name _____ Relationship to Patient _____
Home _____ Work _____ Ext. _____ Cell _____

DENTAL HISTORY

Do you currently have any dental complaints? NO YES (If yes, explain) _____

When was your last full mouth x-ray (18 films or panorex) taken? _____ Where? _____

When was your last dental cleaning? _____ Where? _____

Do you use Tobacco? Yes No What kind? _____ How often? _____ Do you use Alcohol? Yes No How often? _____

Please check "yes" or "no" to indicate if you have had any of the following:

- | | | | |
|-----------------------------------|--|-------------------------------|--|
| Bad Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw pain or tiredness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding gums | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lip or cheek biting | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blisters on lips or tongue | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loose teeth or broken filling | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chew on one side of mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cigarette, pipe, or cigar smoking | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Clicking or popping jaw | <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthodontic treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dry Mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain around ear | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fingernail biting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Periodontal treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Food collection between teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to cold | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Foreign objects in mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to heat | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Grinding teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to sweets | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gum swollen or tender | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sores or growths in mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No |



MEDICAL HISTORY

Physician's name _____ Physician phone _____ Last Visit _____

Pharmacy Name _____ Location _____ Pharmacy Phone _____

Please check "yes" or "no" to indicate if you have had any of the following:

- AIDS, Anemia, Arthritis, Rheumatism, Asthma, Back Problems, Cancer, Chemical Dependency, Chemotherapy, Circulatory Problems, Cortisone Treatments, Cough-persistent/bloody, Emphysema, Epilepsy, Fainting or dizziness, Glaucoma, Headaches, Heart Problems, Hepatitis Type, Herpes, High Blood Pressure, HIV Positive, Jaundice, Jaw Pain, Kidney Disease, Leukemia, Liver Disease, Low Blood Pressure, Nervous Problems, Psychiatric Care, Radiation Treatment, Respiratory Disease, Scarlet Fever, Sinus Trouble, Skin Rash, Special Diet/Weight loss, Stroke, Swollen Feet or Ankles, Swollen Neck Glands, Thyroid Problems, Tuberculosis, Tumors or Growths, Ulcer/Stomach Prob., Venereal Disease, Have you ever had or been diagnosed with: Artificial Heart Valves, Stents or Stunts, Artificial Joints, Hip, Knees, Screws, Pins, Bleeding abnormally, with Extractions or surgery, Blood Disease, Congenital Heart Lesions, Diabetes, Heart Murmur, Hernia Repair, Mitral Valve Prolapse, Pacemaker, Rheumatic Fever, Women: Pregnant, Due Date, Estrogen, Using Birth Control

Have you ever taken any of these medications ?

- Blood Thinners: Coumadin, Warfarin; Diet Medications: Dexfenfluramine, Fen-phen, Pondimin, Redux; Levoxyl, Synthroid

Are you allergic to:

- Penicillin, Aspirin, Barbiturates, Codeine, Ibuprofen, Latex, Local Anesthesia, Metals, Other

Are you taking or have you ever taken any of the following medications?

- Aredia (Pamidronate), Zometa (Zoledronate), Fosamax (Alendronate), Actonel (Risedronate), Boniva (Ibandronate), Skelid (Tiladronate), Didronel (Etidronate), Bonetos (Clodronate), Other

Have you ever had any complications following dental treatment ? ... Have you been hospitalized in the last two years? ... Are you currently taking any herbal or diet supplements? If yes, please list

Please PRINT all medications currently taking:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I consent to whatever dental procedures and anesthetics are necessary for the treatment of the above named patient. I also agree to assume full financial responsibility of all treatment rendered.

Print Name _____ Date signed _____ (Patient, Parent, Guardian or Personal Representative)

Signature _____ Date signed _____ (Patient, Parent, Guardian or Personal Representative)