Patient Information

Name____ I prefer to be called__________________________
Birth date ___________________________________Social security # _____________________________
Male_____ Female _______ Single ____ Married_____
Home address ____
City___________________________State_____________________________Zipcode______________________
Home phone ____________________________________ Work phone ________________________________
Cell phone ______________________ _______________Email address ___________________________
How did you hear about our office____
Other family members seen by us ____

Account Information:

Person responsible for account ______________________ Relationship______________________________
Social security #___________________________________ phone number____________________________
Billing address____
Work phone____

Insurance Information

Primary:
Dental coverage: Yes_____ No_______
Insurance Co. name __________________________________ Insurance Co. phone #___________________
Insurance Co. address ____
Group # ____
Insured's name _____________________________Relationship to patient: __________________________
Insured's date of birth ________________________Insured's social security #_____________________
Name of Insured's employer ____

Secondary:

Dental Coverage: Yes _________ No_______ Insurance Co. phone #____________________________________
Insurance Co. address ____

- Dental History -

Previous dentist ______________________ Last date of checkup or cleaning__________

Do you have discomfort in your jaw joint? (TMJ / TMD) Yes __________ No ________

Do your gums ever bleed? Yes___________________________ No _________________

Why have you come to the dentist today? ____

Are you happy with your smile? ____

Please circle the most important feature(s) in your smile that you would like to change.

Color Shape Alignment Length Gaps Gum display Other_______

Have you ever had any of the following diseases or medical problems?

___Yes	___ No	Abnormal Bleeding	___Yes	___ No	Hemophilia
___Yes	___ No	Alcohol / Drug abuse	___Yes	___ No	Hepatitis A, B, C
___Yes	___ No	Anemia	___Yes	___ No	Herpes / Fever blisters
___Yes	___No	Arthritis	___Yes	___ No	High Blood pressure
___Yes	___No	Artificial joints	___Yes	___ No	HIV+ / AIDS
___Yes	___No	Artificial heart valve	___Yes	___ No	Kidney problems
___Yes	___No	Asthma	___Yes	___ No	Liver disease
___Yes	___No	Cancer / Chemotherapy	___Yes	___ No	Low blood pressure
___Yes	___No	Colitis	___Yes	___ No	Pacemaker
___Yes	___No	Congenital Heart Defect	___Yes	___ No	Psychiatric problems
___Yes	___No	Diabetes	___Yes	___ No	Radiation treatment
___Yes	___No	Difficulty breathing	___Yes	___ No	Rheumatic / Scarlet fever
___Yes	___No	Emphysema	___Yes	___ No	Seizures
___Yes	___No	Epilepsy	___Yes	___ No	Shingles
___Yes	___No	Fainting spells	___Yes	___ No	Sickle cell disease / traits
___Yes	___No	Frequent headaches	___Yes	___ No	Sinus problems
___Yes	___No	Glaucoma	___Yes	___No	Stroke
___Yes	___No	Heart Murmur	___Yes	___No	Thyroid problem
___Yes	___No	Heart Attack	___Yes	___No	Tuberculosis (TB)
___Yes	___No	Heart Surgery	___Yes	___No	Ulcers

Have you been hospitalized for any reason? ____

Please list any other serious medical conditions that you have ever had.

____

Physician's name______________________________Phone number___________________________

Are you currently taking any prescriptions or over the counter medications?______________________

Please List____

Do you smoke or use tobacco in any form? ____

Are you allergic to any of the following?

___Yes	___No	Aspirin	___Yes	___No	Erythromycin	___Yes	___No	Metals
___Yes	___No	Codeine	___Yes	___No	Jewelry	___Yes	___No	Penicillin
___Yes	___No	Dental anesthetics	___Yes	___No	Latex	___Yes	___No	Tetracycline

Please list any other drugs/ materials that you might be allergic to.

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For women only: Are you pregnant? __________Nursing_____________taking birth control_______________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsible to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature______________________________ Print name ______________________________Date ____________