PATIENT INFORMATION

Today's date: ____________________

First Name: ________________ MI: _____ Last Name: __________________ Nickname: ____________________

Sex: ❑M ❑F Date of Birth: _________ Age: _____ SS#: _______________ E-mail: ______________________

Address: _________________________ City: _________________________ State: _____ Zip: _______________

Home Phone:______________________ Bus. Phone:_____________________ Cell Phone:____________________

Employer:____ Referred By: _______________________________

Dentist:____ Medical Dr. ________________________________

Driver's License: _____________ Nearest relative not living with you: ____________________ Phone:_______________

Have you ever been a patient of our practice? ❑Yes ❑No

Method of Payment: ❑Cash ❑Check ❑Credit Card

Do you belong to a PPO or HMO: ❑Yes ❑No

Your Next Dental Appointment

Date: ___________

Time: ___________

PERSONAL INFORMATION

Marital Status: ❑Married ❑Divorced ❑Legally Separated ❑Widow ❑Single

Employment: ❑NA ❑Full-Time ❑Part-Time ❑Retired

Student: ❑NA ❑Full-Time ❑Part-Time School Name/Location: ____________________________

RESPONSIBLE PARTY (if self, skip to the next section)

❑Self ❑Spouse ❑Father ❑Mother ❑Other Home Phone:____________________

Name: ____________________________________ SS#: _______________ Date of Birth: _________ Age: _____

Address: __________________________________ City: _______________ State: _____ Zip: _______________

Employer: ____ Phone:______________________

SECONDARY RESPONSIBLE PARTY (if different from above)

❑Spouse ❑Father ❑Mother ❑Other Home Phone:____________________

Name: ____________________________________ SS#: _______________ Date of Birth: _________ Age: _____

Address: __________________________________ City: _______________ State: _____ Zip: _______________

Employer: ____ Phone:______________________

PRIMARY DENTAL INSURANCE COMPANY

Employer:__________________________________

Business Address: ___________________________

Phone:______________________ Plan:__________

Insurance Company: __________________________

Group Name: _______________________________

Group #: ___________________________________

Identification #: ____________________________

Primary Insured: _____________________________

Relationship to Primary Insured: ________________

SECONDARY DENTAL INSURANCE COMPANY

Employer:__________________________________

Business Address: ___________________________

Phone:______________________ Plan:__________

Insurance Company: __________________________

Group Name: _______________________________

Group #: ___________________________________

Identification #: ____________________________

Primary Insured: _____________________________

Relationship to Primary Insured: ________________

DENTAL INFORMATION

Reason for today's visit: ❑Emergency ❑Exam ❑Schedule Procedure ❑Consultation

Are you in any pain? ❑Yes ❑No If yes, how long have you been in pain? ______________________________

Please indicate if you have any of the following problems by checking off the corresponding box:

❑Discomfort, Clicking or Jaw Popping ❑Lost or Broken Filling(s) ❑Stained Teeth

❑Red, Bleeding or Swollen Gums ❑Teeth Grinding ❑Locking Jaw

❑Sensitive Tooth or Gums ❑Ringing Ears ❑Bad Breath

❑Blisters/Sores in or Around the Mouth ❑Broken/Chipped Tooth ❑Other (please explain below)

Other: ____

____

Have you ever required pre-medication? ❑Yes ❑No ❑Not Sure

Previous dentist: ____ Phone: ___________________________

Last dental exam: ______________________________ Last dental x-rays: ____________________________

How many times per day do you brush? _____________ How many times per week do you floss? ______________

What type of toothbrush bristles do you use? ❑Soft ❑Medium ❑Hard

MEDICAL HISTORY

Are you taking any of the following medications? ❑ Nerve Pills ❑ Pain Killers ❑ Muscle Relaxer ❑ Stimulants ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other (list)

Other medications: ____________________

Do you have or have had any of the following diseases, medical conditions or procedures? Please check proper box.

Y N		Y N		Y N		Y N	
❑❑	Heart Attack/Stroke	❑❑	Thyroid Problems	❑❑	Cancer/Tumors	❑❑	Cosmetic Surgery
❑❑	Heart Surgery/Pacemaker	❑❑	Kidney Problems	❑❑	Shingles	❑❑	X-ray or Cobalt Treatment
❑❑	Heart Murmur	❑❑	Liver Problems	❑❑	Hepatitis	❑❑	Chemotherapy
❑❑	Rheumatic Fever	❑❑	Respiratory Problems	❑❑	HIV/AIDS/ARC	❑❑	Asthma
❑❑	Mitral Valve Prolapse	❑❑	Sinus Problems	❑❑	Arthritis/Rheumatism	❑❑	Difficulty Breathing
❑❑	Artificial Valves	❑❑	Stomach Problems/Ulcers	❑❑	Artificial Bones/Joints	❑❑	Diabetes/Hypoglycemia
❑❑	Heart Disease	❑❑	Psychiatric Problems	❑❑	Emphysema	❑❑	Leukemia
❑❑	Congenital Heart Defect	❑❑	Venereal Disease	❑❑	Fainting/Seizures/Epilepsy	❑❑	Anemia
❑❑	Chest Pains	❑❑	Alcohol / Drug Abuse	❑❑	Severe/Frequent Headache	❑❑	High/Low Blood Pressure
❑❑	Scarlet Fever	❑❑	Tuberculosis TB	❑❑	Frequent Neck Pain	❑❑	Bleeding Problems
❑❑	Nervousness	❑❑	Jaw Problems TMJ/TMD	❑❑	Back Problems	❑❑	Glaucoma

Are you currently or have you taken in the past (either orally or through IV) any of the following drugs:

Y N		Y N	
❑❑	Actonel (Risedronate) for Osteoporosis	❑❑	Aredia (Pamidronate) for Cancer, Pagets
❑❑	Bonefos (Clondronate) for Cancer	❑❑	Boniva (ibandronate) Osteoporosis
❑❑	Didronel(Etidronate) Pagets	❑❑	Fosamax (Alendronate) Osteoporosis, Pagets
❑❑	Ostac (Clondronate) Cancer	❑❑	Skelid (Tiludronate) Pagets's
❑❑	Zometa (Zoledronic Acid) Osteoporosis, Cancer		

MEDICAL HISTORY (continued)

List any other medical condition(s) you have or have had: ____________________

____

____

Are you allergic to the following? ❑ Latex ❑ Tetracycline ❑ Aspirin ❑ Dental Anesthetics ❑ Penicillin/Amoxicillin ❑ Not Sure ❑ Other (list)

Other Allergies: ____________________

Do you smoke? ❑Yes ❑No How many per day? _________ How long have you smoked? ____________

Other tobacco products? ❑Yes ❑No What type of tobacco? _______ How often?________ How long? ___________

Please rate your general health 1-10: ______ Do you wear contact lenses? ❑Yes ❑No

Have you ever taken the drug Phen-fen or Redux ❑Yes ❑No

For women only:

Are you taking Birth Control pills? ❑Yes ❑No

How many children have you birthed? ________

Are you currently pregnant? ❑Yes ❑No If yes, how many months are you? ________

Are you nursing? ❑Yes ❑No

Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with our office. If the account is not paid in full of the date of services and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: ________________________________ Date: ____________

❑Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE
(Office Use Only)

Initials ________ Date ________

Comments ________

Initials ________ Date ________

Comments ________

Initials ________ Date ________

Comments ________