Babcock & Morgan
family dental

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT OR WRITE LEGIBLY

Date: _____

PERSONAL INFORMATION

Name: _____ SS#: _____

Address _____
STREET CITY STATE ZIP

Telephone Home: _____ Business: _____

Cell Phone: _____ Email: _____

Birthdate: _____ Sex: _____ Marital Status: _____ Spouse Name: _____

Occupation: _____ Referred By: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Birthdate: _____ SS# _____

Address _____
STREET CITY STATE ZIP

Telephone Home: _____ Business: _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co.: _____
NAME

_____
STREET CITY STATE ZIP

Employee: _____ Birthdate: _____ SS# _____

Employer: _____ Policy Number: _____

Secondary Insurance Co.: _____
NAME

_____
STREET CITY STATE ZIP

Employee: _____ Birthdate: _____ SS# _____

Employer: _____ Policy Number: _____

I understand that payment is my obligation regardless of insurance or any other third party involvement.	
Signature: **X**	DATE:

I acknowledge that a copy of Notice of Privacy Practices is available to me upon request.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

PATIENT INFORMATION

DENTAL INFORMATION

YES NO

___ ___ Do you like your smile?
___ ___ Do you have jaw pain, facial muscle pain, or migraine headaches?
___ ___ Do your gums bleed when you brush/floss?
___ ___ Have you had any periodontal (gum) treatments?
___ ___ Have you considered or are interested in changing or enhancing your smile?
___ ___ Are your teeth sensitive to cold, hot, sweets or pressure?
___ ___ Do you have headaches, earaches, or neck pains?
___ ___ Have you ever had orthodontic (braces) treatment?
___ ___ Do you wear removable dental appliances?
How do you feel about the appearance of your teeth? _____

_____

MEDICAL INFORMATION

Are you under the care of a physician? If so, what is/are the condition(s) being treated?

_____

Name of Physician _____
Phone number _____
Are you taking any medicine(s) including non-prescription medicine? _____

_____

_____

Women are you pregnant? _____
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, when was this operation done? _____
Has it been recommended that you take an antibiotic before your dental treatment? ____
Do you use tobacco products? What type _____ How often _____

YES NO

___ ___ Abnormal bleeding
___ ___ Anemia
___ ___ Asthma
___ ___ Cardiovascular disease
- ___ Angina
- ___ Artificial heart valves
- ___ Heart murmur
- ___ High blood pressure
- ___ Mitral valve prolapse
- ___ Pacemaker

___ ___ Hepatitis, jaundice or liver disease
___ ___ Ulcers
___ ___ Stroke

YES NO

___ ___ AIDS or HIV infection
___ ___ Arthritis
___ ___ Cancer
___ ___ Diabetes
___ ___ Dry mouth
___ ___ Eating disorder
___ ___ Epilepsy
___ ___ Fainting spells or seizures
___ ___ G.E. reflux
___ ___ Hemophilia
___ ___ Kidney problems
___ ___ Mental health disorders
___ ___ Migraines

ALLERGIES

YES NO

___ ___ Local anesthetics
___ ___ Penicillin or other antibiotics
___ ___ Latex
___ ___ Peanuts

YES NO

___ ___ Aspirin
___ ___ Codeine or other narcotics
___ ___ Iodine
Other _____