Name_____Date of Birth_____ Sex M F

Mailing Address_____Marital Status—single married widowed divorced

City, State, Zip_____ Telephone (Home)_____

Occupation_____ (Work)_____

Responsible party/Guardian_____ (Cell)_____

Social Security Number_____ Primary Spoken Language(s)-_____

MEDICAL HISTORY

Name & Address of Physician

_____

Are you now under the care of your physician?

If yes, for what?_____

Any recent illness or surgery?

If yes, what?_____

Please list all current medications
(including over-the-counter, homeopathic & birth control)

_____

_____
(use back if need additional room)

DO YOU OR HAVE YOU HAD:

Yes No Joint replacement (knee, hip, etc.)
Yes No Heart trouble or valve damage
Yes No Do you have a pacemaker?
Yes No Have your had a cardiac stent or bypass
Yes No High Blood Pressure
Yes No Bacterial endocarditis
Yes No Acid reflux, heartburn or GERD
Yes No Breathing problems (shortness of breath)
Yes No Asthma
Yes No Do you have Lupus
Yes No Hepatitis, Jaundice or Liver problems
Yes No Anemia
Yes No Tuberculosis
Yes No Diabetes
Yes No Kidney or urinary problems
Yes No Cancer or Tumor
Yes No Do you have a port or shunt?
Yes No Convulsions, Seizures or Fainting?
Yes No Arthritis (Osteoarthritis or Rheumatoid)
Yes No Frequent Headaches

DENTAL HISTORY

Are you having discomfort at this time? Yes No

Please explain_____

Date & reason for last dental visit?_____

_____

When was your last dental exam & cleaning?

_____

Yes No Are any of your teeth sensitive to any of the following: heat __ cold __ sweets__

Yes No Have you ever had your teeth straightened?
Yes No Have you ever had a gum infection?
Yes No Previous periodontal or gum treatment?
Yes No Do your gums bleed when you brush?
Yes No Do you have an unpleasant taste in your mouth?
Yes No Do you use chewing tobacco?
Yes No Do you smoke?
Yes No Do you grin or clench your teeth?
How often do you brush your teeth?_____
When?_____
Yes No Do you floss your teeth?
Yes No Have your ever experienced any unfavorable reaction to dental treatment?
What was the cause?_____

HAVE YOUEVER HAD AN UNDESIRABLE REACTION TO:

Yes No Local anesthetics (Novocaine, etc.?)
Yes No Oral surgery or tooth extractions?
Yes No Penicillin, Tetracycline or other antibiotics?
Yes No Other drugs or medications?
Yes No Natural Rubber Latex
Yes No Allergy to nickel or costume jewelry?

Yes No Have you had your spleen removed?
Yes No AIDS/HIV virus
Yes No MRSA (antibiotic resistant staff infection)
Yes No Other (specify)_____
Yes No Do you have an advanced directive? (age 18 & up)

FEMALES

Yes No Are your pregnant? How may weeks?_____
Yes No Are you nursing?
Yes No Are you taking birth control pills?

Insurance Information

Yes No Do you have Medicaid (MCNA Dental)?

Yes No Do you have dental insurance?

If yes, please complete the information below:

Name of Insured: _____

Date of birth of Insured: __/__/____

Yes No Do you have secondary dental insurance?

If yes, I authorize my insurance company to pay to the dentist, or dental group, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

Signature:_____

I acknowledge I have ben offered a copy of this office's Notice of Privacy Practices. I understand that I am financially responsible for all charges, whether or not they are paid by insurance. I consent to treatment as recommended for my dental care.

SIGNATURE:_____ DATE: ___/___/_____
(PATIENT, PARENT OR GUARDIAN)

We appreciate the opportunity to provider your dental care. Why did you choose our office?_____

Name of who recommend our office?_____