PATIENT INFORMATION

CONFIDENTIAL

PATIENT # ____________

(PLEASE PRINT)

DATE ____________

NAME ____________ FIRST MI LAST BIRTHDATE ____________ HOME PHONE ____________

ADDRESS ____________ CITY ____________ STATE ______ ZIP ______

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT'S EMPLOYER ____________ WORK PHONE ____________

BUSINESS ADDRESS ____________ CITY ____________ STATE ______ ZIP ______

SPOUSE OR PARENT'S NAME ____________ EMPLOYER ____________ WORK PHONE ____________

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE ____________ CITY ____________ STATE ______

PERSON TO CONTACT IN CASE OF AN EMERGENCY ____________ PHONE ____________

WHOM MAY WE THANK FOR REFERRING YOU? ____________

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ____________ RELATIONSHIP TO PATIENT ____________

ADDRESS ____________ HOME PHONE ____________

SOCIAL SECURITY NUMBER ____________

EMPLOYER ____________ WORK PHONE ____________

ADDRESS ____________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED ____________ RELATIONSHIP TO PATIENT ____________

BIRTHDATE ____________ SOCIAL SECURITY NUMBER ____________ DATE EMPLOYED ____________

NAME OF EMPLOYER ____________ WORK PHONE ____________

ADDRESS OF EMPLOYER ____________ CITY ____________ STATE ______ ZIP ______

INSURANCE COMPANY ____________ GROUP # ____________ UNION OR LOCAL # ____________

INS. CO. ADDRESS ____________ CITY ____________ STATE ______ ZIP ______

HOW MUCH IS YOUR DEDUCTIBLE? ______ HOW MUCH HAVE YOU USED? ______ MAX. ANNUAL BENEFIT? ______

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED ____________ RELATIONSHIP TO PATIENT ____________

BIRTHDATE ____________ SOCIAL SECURITY NUMBER ____________ DATE EMPLOYED ____________

NAME OF EMPLOYER ____________ WORK PHONE ____________

ADDRESS OF EMPLOYER ____________ CITY ____________ STATE ______ ZIP ______

INSURANCE COMPANY ____________ GROUP # ____________ UNION OR LOCAL # ____________

INS. CO. ADDRESS ____________ CITY ____________ STATE ______ ZIP ______

HOW MUCH IS YOUR DEDUCTIBLE? ______ HOW MUCH HAVE YOU USED? ______ MAX. ANNUAL BENEFIT? ______

X ____________

SIGNATURE OF PATIENT OR PARENT IF MINOR

PATIENT NAME ______ TODAY'S DATE ______

HOME ADDRESS ______ DATE OF BIRTH ______

______ HOME PHONE ______

BUSINESS ADDRESS ______ BUSINESS PHONE ______

______ SOC. SEC. NO. ______

PATIENT NAME

PATIENT MEDICAL HISTORY

PHYSICIAN ______ OFFICE PHONE ______ DATE OF LAST EXAM ______

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐

IF YES, WHAT MEDICATION(S) ARE YOU TAKING? ______

______

	YES	NO
4. DO YOU USE TOBACCO?	☐	☐
5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	☐	☐
6. ARE YOU WEARING CONTACT LENSES?	☐	☐

7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS? IF YES, PLEASE SPECIFY.

______

______

8. WHEN WAS YOUR LAST COMPLETE PHYSICAL? ______

9. WOMEN ONLY:	YES	NO
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

10. PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

- ☐ HIGH BLOOD PRESSURE
- ☐ HEART ATTACK
- ☐ RHEUMATIC FEVER
- ☐ SWOLLEN ANKLES
- ☐ FAINTING / SEIZURES
- ☐ ASTHMA
- ☐ LOW BLOOD PRESSURE
- ☐ EPILEPSY / CONVULSIONS
- ☐ LEUKEMIA
- ☐ DIABETES
- ☐ HEART DISEASE
- ☐ CARDIAC PACEMAKER
- ☐ HEART MURMUR
- ☐ ANGINA
- ☐ FREQUENTLY TIRED
- ☐ ANEMIA
- ☐ EMPHYSEMA
- ☐ CANCER
- ☐ ARTHRITIS
- ☐ JOINT REPLACEMENT OR IMPLANT
- ☐ CHEST PAINS
- ☐ EASILY WINDED
- ☐ STROKE
- ☐ HAY FEVER / ALLERGIES
- ☐ TUBERCULOSIS
- ☐ RADIATION THERAPY
- ☐ GLAUCOMA
- ☐ RECENT WEIGHT LOSS
- ☐ LIVER DISEASE
- ☐ HEART TROUBLE
- ☐ KIDNEY DISEASES
- ☐ AIDS OR HIV INFECTION
- ☐ THYROID PROBLEM
- ☐ HEPATITIS / JAUNDICE
- ☐ SEXUALLY TRANSMITTED DISEASE
- ☐ STOMACH TROUBLES / ULCERS
- ☐ RESPIRATORY PROBLEMS
- ☐ OTHER ______

______

______

COMMENTS

______

______

______

PATIENT DENTAL HISTORY

PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? ☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? ☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? ☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? ☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? ☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? ☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?
   A) CLICKING? ☐
   B) PAIN (JOINT, EAR, SIDE OF FACE)? ☐
   C) DIFFICULTY IN OPENING OR CLOSING? ☐
   D) DIFFICULTY IN CHEWING? ☐
8. DO YOU HAVE FREQUENT HEADACHES? ☐
9. DO YOU CLENCH OR GRIND YOUR TEETH? ☐
10. DO YOU BITE YOUR LIPS OR CHEEKS, FREQUENTLY? ☐
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST? ☐
12. HAVE YOU HAD ANY ORTHODONTIC WORK? ☐
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS? ☐
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? ☐
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS? ☐

I certify that I have read and understand the above information, to the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X ______ ______

PATIENT, PARENT OR GUARDIAN DATE

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