TODAY'S DATE_____

Thank you for choosing our practice for your dental needs. Please complete this form in its entirety. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help!

PATIENT INFORMATION (PLEASE PRINT)

NAME (FIRST, MI, LAST):_____ DOB:_____ SS#: _____

ADDRESS: _____ CITY: _____ ST: ____ ZIP: _____

CELL: _____ WORK: _____ EMAIL ADDRESS:_____

PREFERRED CONTACT METHOD? CELL□ HOME□ WORK□ EMAIL□ TEXT□

ARE YOU: MARRIED□ SINGLE□ DIVORCED□ WIDOWED□

EMPLOYER: _____OCCUPATION:_____

EMPLOYERS ADDRESS: _____CITY:_____ST:_____ZIP:_____

SPOUSE'S NAME: _____DOB:_____OCCUPATION:_____

IF YOU ARE A STUDENT, NAME OF SCHOOL/ COLLEGE_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

IN CASE OF EMERGENCY, PLEASE CONTACT: _____ PHONE#: _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: _____ DOB: _____

RELATIONSHIP TO PATIENT: SELF□ SPOUSE□ PARENT□

ADDRESS:_____ CITY:_____ ST: _____ ZIP:_____

EMPLOYER:_____ OCCUPATION:_____

INSURANCE INFORMATION

NAME OF INSURED: _____ DOB: _____ SS#: _____

RELATIONSHIP TO PATIENT: SELF□ SPOUSE□ PARENT□

INSURANCE COMPANY NAME: _____ PHONE NUMBER: _____

MEMBER ID: _____ GROUP #: _____ GROUP (EMPLOYER): _____

DO YOU HAVE SECONDARY INSURANCE AS WELL? YES□ NO□ IF YES, PLEASE FILL OUT ADDITIONAL INFORMATION BELOW:

NAME OF INSURED: _____ DOB: _____ SS#:_____

RELATIONSHIP TO PATIENT: SELF□ SPOUSE□ PARENT□

INSURANCE COMPANY NAME: _____ PHONE NUMBER: _____

MEMBER ID: _____ GROUP #: _____ GROUP (EMPLOYER): _____

MEDICAL AND DENTAL HEALTH HISTORY

Do you have, or have you had, any of the following?

	Yes	No
Heart Problems		
Blood Pressure problems	□	□
Heart Murmur	□	□
Heart Valve Problems	□	□
Taking Heart Medication	□	□
Rheumatic Fever	□	□
Pacemaker	□	□
Artificial Heart Valve	□	□
Blood Problems		
Easy Bruising	□	□
Frequent Nosebleeds	□	□
Abnormal Bleeding	□	□
Blood Disease (Anemia)	□	□
Respiratory Problems		
Sinus Problems	□	□
Taking Allergy Medication?	□	□
Asthma	□	□
Tuberculosis	□	□
Other_____	□	□
Intestinal Problems		
Ulcers	□	□
Kidney or Bladder Problems	□	□
Bone or Joint Problems		
Arthritis	□	□
Back or Neck Pain	□	□
Joint Replacement (e.g. total, pins, or implants)	□	□
Fainting, Seizures, or Epilepsy	□	□
Stroke(s)	□	□
Frequent or severe headaches	□	□
Thyroid Problems	□	□
Cancer/ Tumor(s)	□	□
Other: _____		
_____		
Diabetes	□	□
Do you drink alcohol?	□	□
Do you smoke?	□	□
Hepatitis, jaundice, or Liver trouble	□	□
Herpes or other STD	□	□
HIV- Positive/ AIDS	□	□

Please list all medications you are currently taking:

_____
_____
_____
_____
_____

Do you have any known allergies?

_____
_____
_____

Do you take medications or pills for pain or discomfort? (e.g., OTC pain relievers, muscle relaxants, or antidepressants?) □ □

Are there things you would like to change about your smile? □ □

Are you apprehensive about Dental treatment? □ □

Have you had problems in the past with dental treatment? □ □

How often do you brush your teeth? _____

How often do you floss? _____

Do you feel you have Dry Mouth?	□	□
Do you gag easily?	□	□
Do you currently wear dentures or partials?	□	□
Do you have difficulty chewing your food?	□	□
Does food catch between your teeth?	□	□
Do your gums bleed easily?	□	□
Do your gums feel tender or swollen?	□	□

Are your teeth sensitive to any of the following:

Hot foods or liquids?	□	□
Cold food or liquids?	□	□
Sweet/ Sour foods or liquids?	□	□
Do you clench/ grind your teeth?	□	□

Does jaw pain or discomfort affect your appetite, sleep, or other daily routines? □ □

By signing this form, I agree that the above information provided is correct to the best of my knowledge. I understand that this information is used for the purpose of my dental health and will only be shared with my insurance company (if applicable) and those I consent to.

Patient Signature: _____

Doctor Signature: _____