

Patient Information

Patient Name: _____ Preferred Name: _____
Last, First, Middle Initial

Male Female Married Single Child Other

Social Security #: _____ Birth date: _____

Phone (home): _____ (Work) _____ (Other) _____

Email Address: _____

Do you prefer being contacted by phone or email message? _____

Address: _____
Street Apartment #

_____ City State Zip Code

Employer's Name/Address _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No
Last, First, MI

Insured's Birth Date: _____ ID# _____ Group _____

Insured's Address: _____
Street City/State Zip

Insured Employer's Name: _____
Address: _____
Street City/State Zip

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan name and address: _____

Secondary

Insurance Plan name and address: _____

Responsible Party Information

The following is for: Patient's Spouse Person Responsible for Payment

Patient Name: _____ Preferred Name: _____
Last, First, Middle Initial

Male Female Married Single Child Other

Social Security #: _____ Birth date: _____

Phone (home): _____ (Work) _____ (Other) _____

Address: _____
Street Apartment # City/State Zip

Referral Information

Who may we thank for referring you to our practice?

Another patient, friend Another patient relative Dental Office Yellow Pages Newspaper
Office Sign Other: _____

Name of person or office referring you to our practice: _____

Dental History

Date of last dental visit: _____ Reason for today's visit: _____

Does dental treatment make you nervous? No Slightly Moderately Extremely

Do you presently or have ever had any of the following?

- | | |
|---|--|
| <input type="checkbox"/> Clenching or grinding | <input type="checkbox"/> Jaw pops or clicks |
| <input type="checkbox"/> Pain in or around ear | <input type="checkbox"/> Frequent headaches |
| <input type="checkbox"/> Difficulty opening/closing | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Gum surgery | <input type="checkbox"/> Previous periodontal treatment |
| <input type="checkbox"/> Bad dental experience | <input type="checkbox"/> Immediate relative lose all their natural teeth |

Are your teeth sensitive to: Hot Cold Biting Sweets

Are you happy with the appearance of your teeth? Yes No

Patient Health Information

Have you ever had any of the following? Please check those that apply.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Allergies:

_____ | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tumors |
| | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Ulcers |
| | <input type="checkbox"/> Growths:
_____ | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy Due Date:
_____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Other:

_____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Diabetes | | | |

How would you describe your present health? Excellent Good Fair Poor

If yes, please explain. _____

Are you now under the care of a physician? Yes No

If yes, please explain. _____

Name of Physician _____

Are you taking any medication (this includes over-the-counter drugs)? Yes No

If yes, please explain. _____

Do you have any health problems that need further clarification? Yes No

If yes, please explain. _____

Update: _____

To the best of my knowledge all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. This is to certify that I, undersigned, consent to the performing of the dental procedures and oral surgery agreed to be necessary or advisable, including the use of local anesthetics as indicated and I will assume responsibility for fees associated with those procedures.