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PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place in us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If you have any questions, don't hesitate to ask.

Today's date:_____

Patient name:_____ Date of Birth:_____ Age:_____ Sex:_____
LAST FIRST MI

What you prefer to be called:_____

Mailing address:_____ City:_____ State:_____ Zip:_____

Driver's License #:_____ State:_____ SS#:_____

Home Phone #:_____ Cell Phone #:_____ Email:_____

Employer/Occupation:_____ Work Phone #:_____

Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouses Name: _____ Do you have children? ☐ Yes ☐ No How many?_____

Primary dental insurance:_____ Group #:_____

Subscriber's name:_____ Date of birth:_____ SS#:_____

Secondary dental insurance:_____ Group #:_____

Subscriber's name:_____ Date of birth:_____ SS#:_____

EMERGENCY CONTACT Name:_____ Phone #:_____ Relation:_____

Name of your medical doctor:_____ Date of last visit to medical doctor:_____

Name of previous dentist:_____ Date of last visit to dentist:_____

Whom can we thank for referring you?:_____

DENTAL HEALTH HISTORY

	YES	NO
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you have any painful teeth?	☐	☐
Does food catch between your teeth?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you noticed any slow-healing sores/ulcers in or around your mouth?	☐	☐
Are your teeth sensitive with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sweets?	☐	☐

How often do you brush? _____

How often do you floss? _____

What type of toothbrush do you use? Regular or Powerbrush

	YES	NO
Do you have difficulty chewing your food?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you wish you had more teeth to chew with?	☐	☐
Does your jaw make clicking/popping noises?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Does your jaw ever feel sore or tired?	☐	☐
Does it hurt when you chew or open wide to eat?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have jaw symptoms or headaches upon awakening in the morning?	☐	☐
Have you had an injury to the jaw?.	☐	☐
Do you want whiter teeth?	☐	☐

How would you rate your smile?.....(WORST) 1 2 3 4 5 (BEST)

What don't you like about your smile?_____

_____

MEDICAL HEALTH HISTORY

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

	YES	NO
Heart Problems	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
High/low blood pressure	☐	☐
Heart murmur	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Rheumatic fever	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Anemia	☐	☐
Leukemia	☐	☐
Ever have blood transfusion?	☐	☐
Allergy Problems	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Asthma	☐	☐
Mouth breather	☐	☐
Persistant cough or swollen glands	☐	☐
Tuberculosis or Respiratory disease	☐	☐
Cancer/Tumor	☐	☐

	YES	NO
Intestinal Problems	☐	☐
Ulcers or acid reflux	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Osteoporosis	☐	☐
Joint replacement (e.g.,total hip, pins, implants)	☐	☐
Fainting spells, seizures	☐	☐
Epilepsy or neurological disease	☐	☐
Stroke(s)	☐	☐
Frequent or severe headaches	☐	☐
History of head injury?	☐	☐
Diabetes	☐	☐
Check your blood sugar daily.	☐	☐
Family history of diabetes	☐	☐
Glaucoma	☐	☐
Thyroid problems	☐	☐
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV+ or AIDS	☐	☐

	YES	NO
Do you drink alcohol?	☐	☐
If so, how much?_____		
Do you smoke?	☐	☐
If so, how much?_____		
Current or history of alcohol abuse	☐	☐
Current history of drug abuse	☐	☐
Do you wear contact lenses?	☐	☐

Do you have any disease, condition, or problem not listed previously that you feel we should know about?

_____

_____

_____

WOMEN

	YES	NO
Are you taking birth control pills?	☐	☐
Are you pregnant?	☐	☐
If so, due date_____		
Are you nursing?	☐	☐

ALLERGIES

Are you allergic, or have you reacted adversely, to any of the following?	YES	NO
Local anesthetics ("Novocaine)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐

Other:_____

_____

MEDICATIONS

	YES	NO	DON'T KNOW
Premedication required by physician?	☐	☐	☐

What Prescription medications are you taking?

_____

_____

_____

_____

_____

Vitamin/Supplements/Natural Remedies:

_____

_____

_____

∞ We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

∞ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting your account.

∞ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

∞ I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes to the information I have provided

Patient/Guardian Signature :_____Date:_____

UPDATE (OFFICE USE)

	Initial	Date
1.	_____ /	_____
2.	_____ /	_____
3.	_____ /	_____
4.	_____ /	_____
5.	_____ /	_____
6.	_____ /	_____