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PATIENT INFORMATION

Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐

(Please Print) _____ Birth Date _____ Home Phone _____
(First) (Mi) (Last)

Address _____ City_____ State_____ Zip_____

Name you prefer to be called _____ SSN # _____

Employer _____ Position _____ Work Phone _____

Cell Phone _____ Email _____

Marital Status _____ Spouse Name (if applicable) _____ Phone _____

Whom may we thank for referring you? _____

Emergency Contact _____ Relation _____ Phone _____

Name of Person Responsible for the Account _____

DENTAL INSURANCE

Do you have dental insurance YES ☐ NO ☐ Who is the subscriber? Self ☐ Spouse ☐ Other ☐

Subscribers Name _____ Birth Date_____ SSN # or Member ID# _____
(First) (Last)

Address _____ City_____ State_____ Zip_____
(If different from patient)

Employer _____ Insurance Company _____

Group/Policy Number _____ Insurance Provider Phone Number _____

PATIENT DENTAL HISTORY

Reason for today's visit _____

Previous Dentist _____

Last Dental Visit _____

Check all that apply:

1. Are you having any dental pain or discomfort at this time? ☐
2. Do you feel very nervous about having dental treatment? ☐
3. Have you ever had a bad experience in the dental office? ☐
4. Do your gums bleed while brushing or flossing? ☐
5. Are your teeth sensitive to hot or cold liquids/foods? ☐
6. Are your teeth sensitive to sweet or sour liquids/foods? ☐
7. Do you have any sores or lumps in or near your mouth? ☐
8. Have you had any head, neck or jaw injuries? ☐
9. Do you have frequent headaches? ☐
10. Do you clench or grind your teeth? ☐
11. Do you bite your lips or cheeks frequently? ☐
12. Have you ever experienced any of the following problems in your jaw?
    a.) Clicking? ☐
    b.) Pain (joint, ear, side or face?) ☐
    c.) Difficulty in opening and closing? ☐
    d.) Difficulty in chewing? ☐
13. Have you ever had periodontal surgery or been told you have gum disease? ☐
14. Have you had any orthodontic work? ☐
15. Have you ever had prolonged bleeding? ☐
16. Have you ever had instruction on the correct method of brushing your teeth? ☐
17. Have you ever had instruction on care of your gums? ☐

- Have you been a patient in the hospital during the past two years? Yes No
- Have you been under the care of a medical doctor during the past two years? Yes No
- Physician's Information_____
  (NAME) (PHONE)
- Are you now taking any medication, drugs, or supplements including oral contraceptives? Yes No
  If YES, **please list all medications:** _____
  _____
- **Please check if you are allergic to any of the following drugs:**

  Penicillin ☐ **Erythromycin** ☐ **Dental Anesthetics** ☐ **Aspirin** ☐ **Tetracycline** ☐ **Codeine** ☐
  Acrylic ☐ **Latex** ☐ **Sulfa Drugs** ☐ **Metal** ☐

- Are you allergic to any other drugs, medications or substances? If yes, please list: _____
  _____

Please indicate which of the following you have had or have at present. Circle "YES" or "NO" to each item

AIDS/HIV Positive	YES NO	Drug Addiction	YES NO	Hypoglycemia	YES NO
Allergies /Hay Fever	YES NO	Emphysema	YES NO	Irregular Heartbeat	YES NO
Alzheimer's Disease	YES NO	Epilepsy/Seizures	YES NO	Kidney Problems	YES NO
Anaphylaxis	YES NO	Excessive Bleeding	YES NO	Liver Disease	YES NO
Anemia	YES NO	Fainting Spells/Dizziness	YES NO	Mitral Valve Prolapse	YES NO
Angina	YES NO	Frequent Cough	YES NO	Osteoporosis	YES NO
Arthritis/Gout	YES NO	Frequent Diarrhea	YES NO	Psychiatric Care	YES NO
Artificial Heart Valve	YES NO	Herpes or Venereal Disease	YES NO	Radiation Treatments	YES NO
Artificial Joint	YES NO	Glaucoma	YES NO	Rheumatic Fever	YES NO
Asthma	YES NO	Heart Attack/Failure	YES NO	Rheumatism	YES NO
Blood Disease	YES NO	Heart Disease	YES NO	Scarlet Fever	YES NO
Blood Transfusion	YES NO	Heart Murmur	YES NO	Sickle Cell Disease	YES NO
Bruise Easily	YES NO	Heart Pacemaker	YES NO	Sinus Problems	YES NO
Cancer	YES NO	Heart Surgery	YES NO	Stroke	YES NO
Chemotherapy	YES NO	Hemophilia	YES NO	Taking Blood Thinners	YES NO
Chest Pains	YES NO	Hepatitis A	YES NO	Thyroid Disease	YES NO
Cold Sores/Fever Blisters	YES NO	Hepatitis B or C	YES NO	Tuberculosis	YES NO
Congenital Heart Disorder	YES NO	High Blood Pressure	YES NO	Tumors	YES NO
Cortisone	YES NO	High Cholesterol	YES NO	Ulcers	YES NO
Diabetes	YES NO	Hives or Rash	YES NO	Yellow Jaundice	YES NO

- During normal activities do you experience shortness of breath, chest pains or have awakened with shortness of breath?_____ YES NO
- Do your ankles swell during the day? _____ YES NO
- Do you smoke or use other tobacco products? If yes, how much? _____ YES NO
- Have you gained or lost more than 10 pounds in the past year? _____ YES NO
- Have you ever had any bleeding problems following injuries or dental treatment? _____ YES NO
- Has your physician diagnosed you with any disease or condition not listed above? _____ YES NO
  (If yes, please explain) _____
- **(FOR WOMEN ONLY)** Are you pregnant? YES NO What month? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge

Patient's Signature: _____ Date: _____

CONSENT

The underlying hereby authorizes the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize doctor to perform any and all forms of treatment, medication and therapies that may be indicated in connection with (***name of patient***) _____ and further authorize and consent the doctor to choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.

Patient's Signature: _____ Date: _____