



## Patient Information

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Gender:** \_\_\_\_\_ **Family Status:** \_\_\_\_\_  
**SSN:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_  
**Phone (Home):** \_\_\_\_\_ **(WORK):** \_\_\_\_\_ **Ext:** \_\_\_\_\_  
**Cell Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

## Health Information

**Date of Last Dental Visit:** \_\_\_\_\_ **Reason for visit:** \_\_\_\_\_

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

- |   |   |   |   |   |
|---|---|---|---|---|
| <input type="checkbox"/> Aids                     | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Stroke   |
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Hay Fever            | <input type="checkbox"/> Tuberculosis   |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Mental Disorder      | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Tumors   |
| <input type="checkbox"/> Angina                   | <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Nervous Disorder     | <input type="checkbox"/> Heart Attack         | <input type="checkbox"/> Ulcers   |
| <input type="checkbox"/> Arteriosclerosis         | <input type="checkbox"/> Growths            | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Head Injuries        | <input type="checkbox"/> Blood Disease        | <input type="checkbox"/> Codeine Allergy  |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Jaundice           | <input type="checkbox"/> Hepatitis A B C      | <input type="checkbox"/> Radiation            | <input type="checkbox"/> Seizures   |
| <input type="checkbox"/> Sinus Problems           | <input type="checkbox"/> Rheumatism         | <input type="checkbox"/> Stomach Problems     | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Latex Allergy  |
| <input type="checkbox"/> Cardiovascular Disease   | <input type="checkbox"/> High/Low Pressure  | <input type="checkbox"/> Artificial Joints    | <input type="checkbox"/> Local Anesthetic     | <input type="checkbox"/> Penicillin Allergy   |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Mitro Valve Prolapse | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Other _____<br><input type="checkbox"/> Pregnancy Due Date _____ |

- Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_
  
- Have you been admitted to a hospital or needed emergency care during the past two years?  
 Yes  No if yes, please explain: \_\_\_\_\_

- Are you now under the care of a physician?     \_\_\_ Yes     \_\_\_ No  
If yes, please explain: \_\_\_\_\_
- Name of Physician: \_\_\_\_\_  
Phone: \_\_\_\_\_
- Do you have any health problems that need further clarification?     \_\_\_ Yes     \_\_\_ No  
If yes, please explain: \_\_\_\_\_
- Do you need to pre-medicate prior to a dental appointment? \_\_\_\_\_  
If yes, which antibiotic? \_\_\_\_\_
- Do you have a persistent cough or cough up blood? \_\_\_\_\_
- What medications are you currently taking on a regular basis? \_\_\_\_\_
- Are you allergic to any medications? \_\_\_\_\_
- Do you use tobacco products? \_\_\_\_\_
- Are you HIV Positive? \_\_\_\_\_

### **Women Only**

- Is there a possibility that you might be pregnant? \_\_\_\_\_
- Are you taking any oral contraceptives? \_\_\_\_\_
- Are you nursing? \_\_\_\_\_

### **Dental History**

- How long since you last dental visit? \_\_\_\_\_
- What was done then? \_\_\_\_\_
- Did you have X-Rays taken? \_\_\_\_\_
- Have you lost any teeth? \_\_\_\_\_
- Are your teeth sensitive to heat? \_\_\_\_\_ Cold? \_\_\_\_\_ Sweets? \_\_\_\_\_ Sour? \_\_\_\_\_
- How often do you brush your teeth? \_\_\_\_\_
- Do you use dental floss? \_\_\_\_\_ How often? \_\_\_\_\_
- Do you have bleeding gums? \_\_\_\_\_ When? \_\_\_\_\_
- Do you grind your teeth? \_\_\_\_\_ When? \_\_\_\_\_
- Have you ever had gum treatments? \_\_\_\_\_ When? \_\_\_\_\_
- Are you aware of any swelling or lump in your mouth? \_\_\_\_\_
- Do you hear popping, clicking, or snapping noises when you chew? \_\_\_\_\_
- Have you had any serious trouble associated with any previous treatments? \_\_\_\_\_  
If so, explain \_\_\_\_\_

**Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment.**

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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.

\_\_\_\_\_ **date:** \_\_\_\_\_

**Signature of patient, parent or guardian**

### **Referral Information**

Whom may we thank for referring you to our practice? \_\_\_\_\_

\_\_\_ Yellow Pages \_\_\_ Newspaper \_\_\_ Other

### **Employment Information**

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Phone: \_\_\_\_\_ EXT: \_\_\_\_\_ Email: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### **Insurance Information**

**Insurance Holders Name** \_\_\_\_\_ **Insured Birth Date** \_\_\_\_\_

**Insurance Plans Name and Address**

\_\_\_\_\_

\_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Phone # \_\_\_\_\_ Payer ID # \_\_\_\_\_

**Insured's Employer** \_\_\_\_\_

Patient's relationship to the insured? \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other

## Spouse or Responsible Party Information

Name: \_\_\_\_\_

SSN# \_\_\_\_\_ Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Patients Signature: \_\_\_\_\_

Doctors Signature: \_\_\_\_\_