PATIENT INFORMATION

Todays Date _____

Name: _____ Occupation: _____

Address: _____ Date of Birth: _____

_____ Home Phone: ( ) _____

Employer: _____ Business Phone: ( ) _____

Soc. Sec. #: _____ Cell Phone: ( ) _____

E-mail _____

Have you or your family ever been seen in this office? ❑ Yes _____ ❑ No

Sex: ❑ Male ❑ Female

Whom can we thank for the referral?

Name: _____ Relationship: _____

Address: _____ Phone Number: _____

Other sources: ❑ Yellow Pages

❑ Other _____

FINANCIAL INFORMATION

Payments are due at time of service unless arrangements are made in advance

Person Responsible For The Account

Name: _____ Relationship: _____

Address: _____

Employer: _____ Telephone: _____

Soc. Sec. #: _____

Form of Payment: ❑ Cash ❑ Check ❑ Credit Card: _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE		SECONDARY INSURANCE	
Name of INSURED:		Name of INSURED:	
Name of Insurance Co.:		Name of Insurance Co.:	
Address:	Date of Birth	Address:	Date of Birth
Group Number:	Telephone Number:	Group Number:	Telephone Number:
SS#		SS#	

☞ _____

Signed (Patient, Parent, Guardian)

Reason for Visit

First Visit _____ Emergency _____ If so, explain _____

MEDICAL ALERTS

_____

MEDICAL HISTORY

Date of Last Physical Exam:_____

Are you now or have you recently been under a physician's care? ___YES ____NO

Reason: _____

Have you ever been a patient in a hospital or had any serious illness?

Explain: _____

Check any of the following that you have had or suspected:

YES	NO		YES	NO		YES	NO	
___	___	Arthritis	___	___	Hepatitis or Jaundice	___	___	Prolonged Bleeding
___	___	Rheumatic Fever	___	___	Liver Disease	___	___	Fainting Tendency
___	___	Heart Trouble	___	___	Cancer or Tumor	___	___	Epilepsy
___	___	Heart Murmur	___	___	Tuberculosis	___	___	Thyroid Disease
___	___	High/Low Blood Pressure	___	___	Diabetes	___	___	Glaucoma
___	___	Chest Pain	___	___	Kidney/Bladder Trouble	___	___	Radiation Treatment
___	___	Stroke	___	___	Anemia	___	___	Mental Disorders
___	___	Shortness of Breath	___	___	Lung Disease	___	___	HIV or AIDS
___	___	Asthma or Hay Fever	___	___	Venereal Disease	___	___	Prosthetic Joint Replacement
___	___	Sinus Trouble	___	___	Blood Disease	___	___	Blood Transfusion

Explanation or Additional Comments:

_____

_____

_____

_____

_____

	YES	NO
Do you feel you have bad breath (halitosis)?	___	___
Do your gums bleed when you brush?	___	___
Have you had root canal work done before?	___	___
Do you have crown, bridges, partial or full dentures?	___	___
Have you had gum surgery?	___	___
Do you have teeth implants?	___	___
Do you have chronic headaches, neck or shoulder pain?	___	___
Do you have pain in or around the ears?	___	___
Do you have trouble sleeping?	___	___
Do you clench your teeth during the day or night?	___	___
Do your jaws click/pop when you open your mouth?	___	___
Has your jaw ever locked in the open or closed position?	___	___
When was the last time you had dental x-rays taken? _____		

Check any of the following that you are taking or have taken:

___ Cortisone Drugs ___ Anticoagulants ___ Tranquilizers ___ Steroids ___ Blood thinners ___ Sedatives

Are you taking any other medication? ___ YES ___ NO If yes, explain:

_____

Are you allergic to or do you suffer ill effects from any of the following:

___ Penicillin ___ Codeine ___ Dental Anesthesia ___ Aspirin ___ Household Bleach ___ Other:_____

Explanation or Additional Comments:

_____

_____

_____

_____

Women Only: Are you pregnant? ____ YES ____ NO

If yes: How many months? _____ Are you breast feeding? ____

Are you presently taking medicine of any kind routinely?

(Birth control pills, shots, or implant, hormone therapy, etc).____

Explain: _____

The above information is true to the best of my knowledge.
RESPONSIBLE PARTY FOR PATIENT:

Name and Address: _____

Signature: _____