Date _____

Confidential Patient Information

ABC

Patient's Name _____ Marital Status _____
Last First Middle

Address _____
Street City State Zip

Telephone # Home: _____ Work: _____ Cell: _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Confidential Responsible Party Information

Name _____ Marital Status _____
Last First Middle

Residence _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Driver's License # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Policy Holder's name _____ Social Security # _____ Date of Birth _____

Insurance Company _____ Group No. _____ Policy # _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's name _____ Social Security # _____ Date of Birth _____

Insurance Company _____ Group No. _____ Policy # _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship: _____

I understand that where appropriate, credit bureau reports may be obtained. If I cancel/reschedule my appointment in less than 24 working hours, I will pay $25 for every 30 minutes of scheduled time.

Signature (parent's signature if minor) _____

Updates (date & initial) _____

CONFIDENTIAL (For record and pretreatment evaluation)

Dental History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

How many times a week do you floss? _____

How many times a day do you brush? _____ How long do you use a tooth brush before replacing it? _____

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? ☐ Yes ☐ No If yes, why? _____

_____

Medical History

Your current physical health is: ☐ **Good** ☐ **Fair** ☐ **Poor**

Are you currently under the care of a physician? ☐ Yes ☐ No Please explain: _____

_____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No If yes, how much for how long? _____

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No

Please list each one _____

_____

For Women: Are you taking birth control pills? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Anemia	☐ Yes	☐ No
High / Low Blood Pressure	☐ Yes	☐ No
Heart Attack / Stroke	☐ Yes	☐ No
Heart Surgery / Pacemaker	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No
Mitral Valve Prolapse (MVP)	☐ Yes	☐ No
Rheumatic / Scarlet Fever	☐ Yes	☐ No
Epilepsy / Seizures	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Tuberculosis (TB)	☐ Yes	☐ No
Artificial Bones / Joint	☐ Yes	☐ No
Artificial Valves	☐ Yes	☐ No
Difficulty Breathing / Emphysema	☐ Yes	☐ No
Asthma	☐ Yes	☐ No

Arthritis	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Hemophilia / Abnormal Bleeding	☐ Yes	☐ No
Cancer / Chemotherapy / Radiation Treatment	☐ Yes	☐ No
HIV + / AIDS	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No
Fever Blisters / Herpes	☐ Yes	☐ No
Shingles	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
Drug / Alcohol Abuse	☐ Yes	☐ No
Ulcers / Colitis	☐ Yes	☐ No
Severe / Frequent headaches	☐ Yes	☐ No
Psychiatric Problems	☐ Yes	☐ No
Sinus Problems	☐ Yes	☐ No
Hospitalized for Any Reason	☐ Yes	☐ No

Are you allergic to any of the following?

Aspirin	☐ Yes	☐ No	Erythromycin	☐ Yes	☐ No	Latex	☐ Yes	☐ No
Codeine	☐ Yes	☐ No	Tetracycline	☐ Yes	☐ No	Any Metal / Plastic	☐ Yes	☐ No
Dental Anesthetics	☐ Yes	☐ No	Penicillin	☐ Yes	☐ No	Other	☐ Yes	☐ No

Please list any other drugs that you are allergic to: _____