

PATIENT INFORMATION

abc

Date _____ Social Security # _____
 Patient's name _____ Marital status _____
 Address _____
 _____ Zip _____ How long? _____
 Birthdate _____ Phone #'s (H) _____ (W) _____
 email address _____
 Employed by _____ How long? _____
 Work Address _____
 Zip _____
 Spouse's name (Parent) _____ Social Security # _____
 Spouse (Parent) employed by _____ How long? _____
 Whom can we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION

Who will pay for this account? _____
 Address _____ Zip _____
 Phone #'s (H) _____ (W) _____
 Credit card # _____ Expiration date _____
 Employed by _____ How long? _____
 Address _____ Zip _____

*I understand that, where appropriate, credit bureau reports may be obtained.
1 1/2 % interest per month will be charged on all overdue balances.*

Signature _____

INSURANCE INFORMATION

Insured's name _____ Social Security # _____
 Insurance company _____ Group# _____ Local# _____
 Insurance company address _____
 Zip _____ Do you have dual coverage? _____
 Insured's name _____ Social Security # _____
 Insurance company _____ Group# _____ Local# _____
 Insurance company address _____
 Insured's employer and address _____ Zip _____

EMERGENCY INFORMATION

In case of emergency, whom should we contact? _____
 Address _____ Zip _____
 Phone #'s (H) _____ (W) _____
 Relationship _____

MEDICAL HISTORY

Physician's name _____ Phone# _____

Date of last physical exam _____ Reason for exam _____

Do you have or ever had any of the following? no _____ yes _____ (check below)

Any heart problems _____	Allergies to anesthetics _____	Hepatitis _____	Rheumatic fever _____
High blood pressure _____	Allergies to penicillin _____	Heart murmur _____	Sinus problems _____
Low blood pressure _____	Allergies to any drugs _____	Herpes _____	Stroke _____
Circulatory problems _____	or medications _____	Malignancies _____	Thyroid problems _____
Nervous problems _____	Allergies to _____	Measles _____	Tonsillitis _____
Radiation treatment _____	Anemia _____	Mitral valve _____	Tuberculosis _____
Excessive bleeding _____	Arthritis _____	prolapse _____	Ulcers _____
Cold sores _____	Asthma _____	Mumps _____	Valve disorders _____
AIDS _____	Diabetes _____	Prosthetic surgery _____	Venerial diseases _____
HIV _____	Epilepsy _____	Psychiatric care _____	Other (explain) _____

If you cut yourself, do you have trouble stopping the bleeding? _____ Do you bruise easily? _____

Women: Are you pregnant or are you breastfeeding? _____

Are you currently under the care of a physician? _____

If so, what is the nature of the care? _____

Are you currently taking any drugs or medications? _____ Which ones? _____

Reasons for medications: _____

DENTAL HISTORY

How long since you've been to a dentist? _____ What was done then? _____

Were x-rays taken? _____ How many? _____ Will you have them transferred to our office? _____

Did you complete all recommended dental work with your previous dentist? _____

If not, why? _____

How often do you brush your teeth? _____ When? _____

Do you use dental floss or other items? _____ When? _____

Are your teeth sensitive to cold? _____ heat? _____ sweet? _____ pressure? _____

Do you have bleeding gums? _____ When? _____

Does food wedge between your teeth? _____ Where? _____

Do you clench or grind your teeth? _____ When? _____

Do you hear popping, clicking or snapping noises when you chew? Do you have ringing in your ears? _____

Are you aware of any swelling, lumps, discolorations or anything unusual in your mouth? _____

Have you ever had gum treatments? _____ root canal work? _____ extractions? _____ implants? _____

Are you fearful of dental treatment? _____ Explain _____

How do you feel about your smile? _____ Explain _____

Are you satisfied with the way your teeth look? _____ Explain _____

What is the purpose of this appointment? _____

Do you smoke? _____ How often? _____

Do you drink? _____ How often? _____

Do you chew gum? _____ How often? _____

DATE _____ SIGNATURE _____

DR.'s COMMENTS _____