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 _____
High blood pressure_____
Low blood pressure _____
Circulatory problems_____
Nervous problems _____
Radiation treatment _____
Excessive bleeding _____
Cold sores _______
AIDS __________
HIV __________

Allergies to anesthetics_____
Allergies to penicillin _____
Allergies to any drugs or medications _____
Allergies to_____
Anemia _____
Arthritis _____
Asthma _____
Diabetes _____
Epilepsy _____

Hepatitis _____
Heart murmur _____
Herpes _____
Malignancies _____
Measles _____
Mitral valve prolapse _____
Mumps _____
Prosthetic surgery_____
Psychiatric care _____

Rheumatic fever _____
Sinus problems _____
Stroke _____
Thyroid problems_____
Tonsilitis_____
Tuberculosis _____
Ulcers _____
Valve disorders _____
Venerial diseases_____
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_______________