

**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 # \_\_\_\_\_ Number \_\_\_\_\_  
 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 _____            | Tonsilitis _____        |
| Radiation treatment _____  | Anemia _____                   | Mitral valve _____       | Tuberculosis _____      |
| Excessive bleeding _____   | Arthritis _____                | prolapse _____           | Ulcers _____            |
| AIDS _____                 | Asthma _____                   | Mumps _____              | Valve disorders _____   |
| HIV _____                  | Diabetes _____                 | Prosthetic surgery _____ | Venerial diseases _____ |
|                            | 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? \_\_\_\_\_

Do you drink? \_\_\_\_\_

Do you chew gum? \_\_\_\_\_

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

DR.'s COMMENTS \_\_\_\_\_