WELCOME

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form.
If you have any questions or need assistance, please ask us!

PATIENT INFORMATION Date

Name: _____ Birthdate: _____ Home Phone (___) _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐M ☐F ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Email: _____ Cell Phone: (____) _____ SSN: _____

If student name of School: _____ City: _____ State: ___ Full time☐ Part Time ☐

Employer: _____Address: _____ Work Phone: (____) _____

Spouse/Parent/Guardian's Name: _____ Number: (___) _____

Spouse/Parent/Guardian's Employer: _____ Number: (___) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____ Phone: (___) _____Relationship: _____

RESPONSIBLE PARTY

Name of Person
Responsible for this account: _____ Relationship to Patient: _____

Address: _____ Home Phone: (_____) _____

Birthdate: _____ Employer: _____ Currently a patient in the office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ Social Security # _____

Employer: _____ Phone Number: (____) _____

Employer Address: _____ City: _____ State: _____ ZIP: _____

Insurance Company: _____ Group #: _____ Group Name: _____

Member ID: _____

Address: _____ City: _____ State: _____ ZIP: _____

ADDITIONAL INSURANCE

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ Social Security # _____

Employer: _____ Phone Number: (____) _____

Insurance Company: _____ Group #: _____ Group Name: _____
Member ID: _____

Address: _____ City: _____ State: _____ ZIP: _____

Medical History

Although dental personnel primarily treat the area around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name: _____ **Phone:** _____ **Date of last medical exam:** _____

What was the exam for? _____ **Current Physician**: _____

Are you having pain or discomfort at this time?	Yes	No
Do you feel very anxious about having dental treatment?	Yes	No
Have you ever had a bad experience in a dental office?	Yes	No
Have you ever been hospitalized or had a major operation?	Yes	No
Are you under the care of a physician?	Yes	No
Have you ever had a serious head or neck injury?	Yes	No
Are you taking any medications or vitamins or herbal supplements?	Yes	No

If yes, please list the medication, dose, & how often: _____
_____

Women	**Y**	**N**
Are you pregnant or trying to get pregnant?	☐	☐
Are you taking contraceptives?	☐	☐
Are you Nursing?	☐	☐

Do you take, or have you taken Phen-Fen or Redux?	Yes	No
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	Yes	No
Are you on a special diet?	Yes	No
Do you use Tobacco?	Yes	No
Do you use controlled substances?	Yes	No

Are you allergic to any of the following?

☐ Aspirin	☐ Metal
☐ Penicillin	☐ Latex
☐ Local Anesthetics	☐ Sulfa Drugs
☐ Acrylic	☐ Other: _____
☐ Codeine	☐ NONE

CIRCLE ALL THAT APPLY:

FAMILY HISTORY UNKNOWN? ☐ **YES** ☐ **NO**

Acid Reflux	Yes	No
AIDS\HIV Positive	Yes	No
Alzheimer's Disease	Yes	No
Anaphylaxis	Yes	No
Anemia	Yes	No
Angina	Yes	No
Arthritis\Gout	Yes	No
Artificial Heart Valve	Yes	No
Artificial Joint:	Yes	No
What Joint? _____		
When? _____		
Asthma	Yes	No
Blood Disease	Yes	No
Blood Transfusion	Yes	No
Breathing Problem	Yes	No
Bruise Easily	Yes	No
Cancer	Yes	No
Type? _____		
Chemotherapy	Yes	No
When? _____		
Chest Pains	Yes	No
Cold Sores\Fever Blisters	Yes	No
Congenital Heart Disorder	Yes	No
Convulsions	Yes	No
Cortisone Medicine	Yes	No
Diabetes	Yes	No
Drug Addiction	Yes	No
Dry Mouth	Yes	No
Easily Winded	Yes	No
Emphysema	Yes	No

Epilepsy\Seizures	Yes	No
Excessive Bleeding	Yes	No
Excessive Thirst	Yes	No
Fainting Spells\Dizziness	Yes	No
Frequent Cough	Yes	No
Frequent Diarrhea	Yes	No
Frequent Headaches	Yes	No
Genital Herpes	Yes	No
Glaucoma	Yes	No
Hay Fever	Yes	No
Heart Attack\Failure	Yes	No
Heart Murmur	Yes	No
Heart Pace Maker	Yes	No
Heart Trouble\Disease	Yes	No
Hemophilia	Yes	No
Hepatitis A	Yes	No
Hepatitis B or C	Yes	No
Herpes	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Hives or Rash	Yes	No
Hypoglycemia	Yes	No
Inflammatory Disease	Yes	No
Type? _____		
Irregular Heartbeat	Yes	No
Kidney Problems	Yes	No
Leukemia	Yes	No
Liver Disease	Yes	No
Low Blood Pressure	Yes	No
Lung Disease	Yes	No

Mitral Val. Prolapse	Yes	No
Osteoporosis	Yes	No
Jaw Pain	Yes	No
Parathyroid Disease	Yes	No
Psychiatric Care	Yes	No
Radiation Treatments	Yes	No
When? _____		
Recent Weight Loss	Yes	No
Renal Dialysis	Yes	No
Rheumatic Fever	Yes	No
Scarlet Fever	Yes	No
Shingles	Yes	No
Sickle Cell Disease	Yes	No
Sinus Trouble	Yes	No
Sleep Apnea	Yes	No
Do you wear a c-pap?	Yes	No
Spina Bifida	Yes	No
Stomach Disease	Yes	No
Stroke	Yes	No
Swelling of Limbs	Yes	No
Thyroid Disease	Yes	No
Tonsillitis	Yes	No
Tuberculosis	Yes	No
Tumors or Growths	Yes	No
Ulcers	Yes	No
Venereal Disease	Yes	No
Yellow Jaundice	Yes	No

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? ☐ **YES** ☐ **NO**

If yes, please explain: _____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in the medical status.

Signature of Patient, Parent, or Guardian: _____ **Date**:_____