Patient Information — Confidential

Welcome!

Date _____

Name _____
first middle last preferred

Address _____ **Drivers license #** _____

City _____ **State** _____ **Zip** _____

Soc. Sec.# _____ **Birth Date** _____ **Age** _____

Sex: ☐ M ☐ F **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Do you have any children or a spouse that are patients here? ☐ **Yes** ☐ **No**

Do you want to be on a separate account from your children and/or spouse? ☐ **Yes** ☐ **No**

Contact Information

Home (____)_____ Work (____)_____

Mobile (____)_____ Fax (____)_____

E-mail _____

In the event of an emergency, who should we contact?

Name _____

Relationship _____

Work Phone (____)_____ Home Phone (____)_____

How did you hear about us?

- ☐ Sign or Store Front
- ☐ Yellow Book
- ☐ Family
- ☐ Friend _____
- ☐ Website
- ☐ Mailing which? _____
- ☐ Other _____

_____

Employer _____ **Occupation** _____

or

Name of school/college _____ **City** _____ **State** _____ **Zip** _____

Responsible Party

Who is responsible for this account? _____ **Relationship** _____

Address _____

City _____ **State** _____ **Zip** _____

Birth Date _____ **Home Phone** (____)_____ **Work Phone** (____)_____

Soc. Sec.# _____ **Are they a patient here?** ☐ **Yes** ☐ **No**

Insurance Information

Name of insured _____ **Relationship** _____ **Employer** _____ **DOB** _____

Soc. Sec.# _____ **Ins. Company** _____ **Ins. ID** _____ **Group #** _____

Do you have any secondary insurance? ☐ **Yes** ☐ **No** **If yes, complete the following?**

Name of insured _____ **Relationship** _____ **Employer** _____ **DOB** _____

Soc. Sec.# _____ **Ins. Company** _____ **Ins. ID** _____ **Group #** _____

Patient Dental History

PATIENT NAME: _____

Are you having any pain? _____
Do you have any sensitivity to hot, cold, or sweets? _____

Does dental treatment make you nervous? _____
If yes, what concerns you most about having dental treatment? _____

Which of the following concern you about dental treatment?

_____ Time "I am very busy."

_____ Fear "I am afraid of one or more things about dental treatment."

_____ Money "I may need or want to make payments."

Have you experienced any of the following problems?

Bleeding Gums	_____	Bad Breath	_____
Soreness in the jaw	_____	Grinding of teeth	_____
Snoring	_____	Frequent Headaches	_____
Trouble chewing	_____	Loose teeth	_____

On a scale of 1-5 with 5 being the highest:
How important is your dental health to you? _____
Where would you rate your dental health? _____
Where would you like your dental health to be? _____

How would you rate your smile? ____ Embarrassing ____ Decent ____ Okay ____ Perfect

When was the last time you had your teeth cleaned? _____

When was the last time you had an Oral Cancer Screening? _____

Is the whiteness of your teeth important to you? _____
Do you use tobacco in any form? How much? _____
Do you routinely drink coffee, tea, or red wine? _____

If I could change my smile, I would:

___ Make them whiter	___ Replace missing teeth
___ Have less gum showing	___ Close spaces
___ Repair chipped teeth	___ Make them straighter
___ Change silver fillings into tooth colored	
___ Replace any old crowns or caps that don't match	

What is your daily routine of cleaning your teeth? How much time do you spend each day doing that?

_____

What is the most important thing to you about your future smile and dental health?

_____

What is the most important thing to you about your dental visit today?

_____

MEDICAL HEALTH HISTORY

PATIENT NAME: _____ **DATE:** _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
Do you use tobacco?	☐	☐
Do you use alcohol? How much? _____	☐	☐
Have you used any illicit drugs? What Substance?_____ How recently?_____	☐	☐
Do you wear contact lenses?	☐	☐

	YES	NO
Are you under medical treatment now? Explain _____	☐	☐
Have you had any surgeries or hospitalization in the past 5 years? Explain _____	☐	☐

For women only	YES	NO
Are you or might you be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

Allergies

YES	NO		YES	NO	
☐	☐	Barbiturates	☐	☐	Penicillin
☐	☐	Aspirin	☐	☐	Other Antibiotics
☐	☐	Sedatives	☐	☐	Local Anesthetics
☐	☐	Iodine	☐	☐	Sulfa Drugs
☐	☐	Latex	☐	☐	Other _____

Medications

List any medications you are currently taking including any over-the-counter medications and herbals:

_____ _____

_____ _____

_____ _____

Are you currently or have you ever taken IV or oral bisphosphonate drugs Yes No

Do you have or have you had any of the following?

	YES	NO		YES	NO		YES	NO
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Other_____	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐			

COMMENTS _____

_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X _____

PATIENT, PARENT OR GUARDIAN DATE