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Patient / Child Information

Patient's Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone _____ Cell Phone _____ Email _____

Birthdate _____ Social Security # _____

If Patient is a minor, give Patient's or Guardian's Name _____

Whom may we thank for referring you to our office _____

Responsible Party Information

Name _____ (Last) _____ (First) _____ (Middle) _____ (Marital Status)

Residence _____ (Street) _____ (City) _____ (State) _____ (Zip)

Mailing Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs) _____ (Street) _____ (City) _____ (State) _____ (Zip)

Birthdate _____ Social Security # _____ Relation to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relation to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____

Do you have dual Coverage? Yes No If yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group # _____ Local # _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

I understand that where appropriate credit bureau reports may be obtained

Signature (Parent's signature if minor) _____ Date _____

Updates (date & initial) _____ _____ _____ _____ _____

Name _____

Date of Birth _____

Medical History

Name and address of physician _____

Last complete physical exam? _____

Are you currently taking any medications? Yes No

If yes, which ones? _____

Do you take aspirin, NSAIDS, or blood thinners? Yes No

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

Allergy to medications
(i.e. penicillin, codeine, local anesthetics, etc) or latex? Yes No

If so, which ones? _____

Damaged Heart Valves	Yes	No	Epilpsy	Yes	No
Artificial Heart Valves	Yes	No	HIV/AIDS	Yes	No
Heart Murmur	Yes	No	Sinus Trouble	Yes	No
Rheumatic Heart Fever	Yes	No	Hepatitis	Yes	No
Heart Disease	Yes	No	Liver Disease	Yes	No
Stroke	Yes	No	Kidney Disease	Yes	No
Heart Attack	Yes	No	Arthritis	Yes	No
Abnormal Blood Pressure	Yes	No	Glaucoma	Yes	No
Congenital Heart Lesions	Yes	No	Ulcers	Yes	No
Tuberculosis or Lung Disease	Yes	No	Diabetes	Yes	No
Anemia	Yes	No	Cancer	Yes	No
Prosthetic Joint Replacement	Yes	No	Asthma	Yes	No

Have you ever had a blood transfusion? Yes No

Have you ever been treated with radiation therapy? Yes No

Are you subject to prolonged bleeding? Yes No

Have you ever taken prescription drugs for weight control
(i.e. Phen-Phen, Redux, etc.) Yes No

Do you have a disease or condition not listed above that you
think we should know about? Yes No

Please list any previous surgeries _____

Women:

Are you taking female hormones or oral contraceptives at this time? Yes No

Are you pregnant at the present time? Yes No

Date: _____ **Signature:** _____

(OVER)

Dental Health

Reason for visit? _____ Former Dentist's Name _____

When was your last dental visit? _____ Frequency of dental cleanings _____

How often do you brush your teeth? _____

Do you live in a fluoridated community? Yes No

Do you use a mouthwash or rinse? _____

Are you fearful in the dental chair? Yes No

Is there anything we can do to make you more comfortable here?

_____

Have you ever had any serious problems associated with dental treatment? Yes No

If so, please explain _____

Do you have or have you ever had any of the following:

Bleeding or sore gums	Yes	No
Unpleasant taste/chronic bad breath	Yes	No
Burning tongue or lips	Yes	No
Blisters or sores of lips or mouth	Yes	No
Swelling(s) or lumps in your mouth	Yes	No
Sensitivity of teeth (hot, cold, sweet, pressure)	Yes	No
Areas of food impaction or catching	Yes	No
Periodontal surgery	Yes	No

Do you have or have you had:

Difficulty and/or pain when opening your mouth such as when yawning	Yes	No
Your jaw getting "stuck", "locked", or "going out"	Yes	No
Noises in the jaw joints	Yes	No
Pain in or about the ears, temples, and/or cheeks	Yes	No
Soreness of jaw muscles	Yes	No
Clenching or grinding your teeth	Yes	No
Do you snore?	Yes	No
If yes, is it disruptive to either you or your partner's sleep?	Yes	No

Do you use tobacco products? Yes No

If yes, what kind? _____ How much? _____ How long? _____

Personalized Smile Evaluation

1. On a scale of 1 to 10 how do you feel about your smile? _____
2. Are your teeth crooked or crowded and is that a concern for you? Yes No
3. Do you have spaces between your teeth that bother you? Yes No
4. Do you like the color of your teeth? Yes No
5. Do you like the shape of your teeth? Yes No
6. What, if anything would you like to change about the appearance of your teeth or smile? _____