

Patient Information

Name _____ Birth Date _____ Age _____ Sex M F
Street address _____ City _____ State _____ Zip _____
Soc. Sec. # _____ Home Phone _____ Cell Phone _____
E-mail Address _____ May we contact you via E-mail Text Message
Employer _____ Occupation _____ Work Phone _____
Employer Address _____
Marital Status _____ Spouse's Name _____ Spouse's Occupation _____
Whom may we thank for referring you? _____
Emergency Contact _____ Relation to Patient _____ Phone _____

Responsible Party Information

Name _____ Birth Date _____
Relation to Patient _____ Phone _____ Soc. Sec. # _____
Address (if different from patient's) _____
Employer _____ Occupation _____ Work Phone _____

Insurance Information

Insured's Name _____ Relation to Patient _____ Birth Date _____
Insurance Company Name _____ Phone _____
Insurance Company Address _____
Insured's Employer _____ Work Phone _____
Soc. Sec. # _____ Subscriber # _____ Group # _____
Will you be using any additional insurance? Yes No

Medical History

Do you have any general health problems? Yes No Please specify _____
Are you currently under physician's care? Yes No Reason _____
Name and phone of physician _____
Are you currently taking any drugs or medications? Yes No Please list _____

Are you allergic to: Penicillin Codeine Latex Other

Are you pregnant? Yes No Nursing? Yes No

Check X if you have or have had any of the following:

- | | | | |
|--------------------------------------------------|------------------------------------------------|------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Prolonged Bleeding |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Healing complications | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |

Signature Of Patient/Legal Guardian _____ Date _____

Dental History

- Are your teeth sensitive to:
Heat? Yes No Cold? Yes No Sweets? Yes No Biting Pressure? Yes No
- Does food constantly get stuck between certain teeth in your mouth?..... Yes No
- Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? Yes No
- Are you dissatisfied with your teeth in any way? Yes No
- Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, etc. Yes No
- Do you have any fillings that show in your front teeth? Yes No
- Do any of your fillings show when you smile? Yes No
- If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth-colored restoration instead? Yes No
- Have you ever had any teeth removed? Yes No
How long have these teeth been missing? _____
- Do your gums bleed when brushing? Yes No
- Do you ever avoid any part of the mouth while brushing? Yes No
- Have you been instructed regarding proper home care? Yes No
- Do you have an unpleasant taste or odor in your mouth? Yes No
- Do you smoke? Yes No
- Do you frequently snack between meals on sweets or chew gum? Yes No
- How often do you brush your teeth? _____
- Do you use dental floss? Yes No
How often? _____
- Do you want to learn to control dental disease and retain your teeth? Yes No
- Has the fear of discomfort kept you from regular dental visits? Yes No
- Are you deeply concerned about the finances required to return your mouth to excellent dental health? Yes No
- When was your last dental appointment? _____
- What did you have done? _____
- How long since your last thorough examination with full mouth x-rays? _____
- What prompted you to seek dental care at this time? _____
- Why did you leave your last dentist? _____

Remarks
