Welcome To Our Office . . .

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Patient Information

Date ______________________

Patient's Name ______________________ (Last / First / Middle)

Address ______________________ (Street / City / State / Zip)

Home Phone ______________ Birthdate ______________ Social Security # ______________

Employer ______________________ Occupation ______________________

E-Mail Address ______________ Work Phone ______________ Cell Phone ______________

If patient is a minor, give parent'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 ______________

E-Mail Address ______________________ ______________ Cell Phone ______________

Previous Address (if less than 3 yrs.) ______________________ (Street / City / State / Zip)

Social Security # ______________ Birthdate ______________ Relationship to Patient ______________

Employer ______________ Occupation ______________ No. Years Employed ____

Spouse's Name ______________________ (Last / First / Middle) Relationship to Patient ______________

Employer ______________ Occupation ______________ No. Years Employed ____

Social Security # ______________ Birthdate ______________ Work Phone ______________

*I understand that where appropriate, credit bureau reports may be obtained.

Insurance Information

Insured's Name ______________________ Insured's Soc. Sec. # ______________

Insurance Company ______________ Group No. ______________ Local No. ______________

Insurance Co. Address ______________________

Do you have dual coverage? Yes ☐ No ☐ If yes:

Insured's Name ______________________ Insured's Soc. Sec. # ______________

Insurance Co. Address ______________________

Insured's Employer ______________________

Emergency Information

Name of nearest relative not living with you ______________________

Relationship (sister, father, etc.) ______________________

Complete Address ______________________

Phone ______________________

*Signature ______________________

Medical History

Physician____ Address & Phone Number_________________________________

Are you in good health?____ If no, explain____

Do you have an existing illness?________________________________ If yes, explain____

Do you bleed excessively when cut?________________________________ Do you smoke?________________ if yes, how much_____________

Are you taking any medications?_______________________________ If yes, please list____

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Do you now have, or have you had, any of the following?____

	YES	NO		YES	NO
1. Heart Disease	______	______	14. Hepatitis	______	______
2. High Blood Pressure	______	______	15. Asthma	______	______
3. Blood Disease	______	______	16. Tuberculosis	______	______
4. Rheumatic Fever	______	______	17. Anemia	______	______
5. Heart Murmur	______	______	18. AIDS	______	______
6. Diabetes	______	______	19. Other	______	______
7. Stroke	______	______	20. Allergy to (a) Penicillin	______	______
8. Epilepsy	______	______	21. (b) Other Antibiotics______	______	______
9. Arthritis	______	______	22. (c) Local Anesthetics_____	______	______
10. Tumor History	______	______	23. (d) Other_______________	______	______
11. Radiation Disease	______	______	24. Are you pregnant? (for women)	______	______
12. Liver Disease	______	______	25. Have you had any type of joint		
13. Kidney Disease	______	______	replacements?	______	______

Dental History

Previous Dentist____ Date of last visit_______________________ Yes No

Last full mouth x-rays____ Last complete dental exam________________

What is your immediate dental concern?____

	Yes	No
Have you had Orthodontics?____	☐	☐
1. Are you troubled with dryness in your mouth?___________________________________	☐	☐
2. Do you have chronic headaches?____	☐	☐
3. Have you ever had periodontal treatment or gum surgery?__________________________	☐	☐
If yes, when?___________________________ By whom?_____________________________		
4. Have you ever been informed you have gum problems?_____________________________	☐	☐
If yes, when?___________________________ By whom?_____________________________		
5. Do your gums bleed when you brush your teeth?_________________________________	☐	☐
6. Are you aware of any growths or swelling in your mouth?__________________________	☐	☐
If yes, where and how long have they existed?___________________________________	☐	☐
7. Are you aware of your jaw clicking, popping, or making grating-like noises?____________	☐	☐
If yes, when?____	☐	☐
8. Do your jaw muscles feel, tired, stiff, or painful?_______________________________	☐	☐
9. Do you grind your teeth during the day? Do you grind your teeth during the night?__________	☐	☐
10. Are you frustrated by needing constant dental repair because of active dental disease?________	☐	☐
11. Are you anxious about dental treatment?______________________________________	☐	☐
12. Are you concerned about the finances required to return your mouth to a state of excellent dental heath?__________	☐	☐
13. Do you use dental floss? if yes, how often?____________________________________	☐	☐
14. What did you like the <u>BEST</u> about your previous dentist?_______________________	☐	☐
15. What did you like the <u>LEAST</u>?____	☐	☐
16. If you could change one thing about the appearance of your smile, what would it be?____________	☐	☐

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