# PATIENT INFORMATION

**Patient Name:_____ Male____ Female____ Date of Birth:_____**

**____Married ____Single ____Child ____Other Social Security #:_____ _____ Email Address:_____**

**Home Phone:_____ Cell Phone:_____ Work Phone:_____**

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

**Whom May We Thank for Referring You to our Practice?:**

**___Coupon Mailer ___Coupon Flyer ___Drive-By/Sign ___Insurance Co**

**___Internet ___Another Patient ___Another Dental Office ___Other (name below):**

**Name of person, office or other source referring you to our practice:**

---

**RESPONSIBLE PARTY INFORMATION**

**Name:_____ Male____ Female____ Date of Birth:_____**

**____Married ____Single ____Child ____Other Email Address:_____**

**Home Phone:_____ Cell Phone:_____ Work Phone:_____**

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

**Employment Information**

**The following is for: ____Patient ____The person responsible for payment**

**Employer Name:_____ Phone #:_____**

**Address:_____City:_____State:_____ Zip:_____**

---

**PRIMARY INSURANCE INFORMATION**

**Name of Insured:_____ Date of Birth:_____**
**ID/Subscriber No:_____ Social Security #:_____ Group #:_____**
**Insured's Address:_____ City_____ State_____ Zip _____**
**Insured's Employer Name:_____**
**Employer Address:_____**
**Patient's Relationship to Insured: ____Self ____ Spouse ____Child ____Other**
**Insurance Plan Name:_____**
**Insurance Address:_____**

**SECONDARY INSURANCE INFORMATION**

**Name of Insured:_____ Date of Birth:_____**
**ID/Subscriber No:_____ Social Security #:_____ Group #:_____**
**Insured's Address:_____ City_____ State_____ Zip _____**
**Insured's Employer Name:_____**
**Employer Address:_____**
**Patient's Relationship to Insured: ____Self ____ Spouse ____Child ____Other**
**Insurance Plan Name:_____**
**Insurance Address:_____**

**PATIENT MEDICAL HISTORY**

**Primary Physician and Office Phone No:_____**

**1. Are you in good health? ____Yes ____No**
**2. When was your last complete physical? _____**
**3. Are you under medical treatment now? ____Yes ____No**
**4. Have you ever been hospitalized for any surgery or serious illness in the last 6 months? ____Yes ____No**
**5. Are you taking any medications, including non-prescription medication? ____Yes ____No**
**If yes, what medications are you taking, what amount and for what (if you have a list to scan in please give it to us)?**
**_____**
**6. Are you allergic to or have you had any reactions to any drugs? ____Yes ____No**
**If yes, please specifiy:_____**
**7. Are you required to take a pre-medication prior to dental treatment? ____Yes ____No**
**If yes, what do you take and why? _____**
**8. Do you use tobacco? ____Yes ____No If yes, how often? _____**
**Check what applies: ____Cigarettes ____Cigars ____Chewing Tobacco ____Other**
**9. Do you consume alcohol? ____Yes ____No If yes, how often? _____**
**10. Do you use any recreational drugs? ____Yes ____No If yes, what kind and how often? _____**
**11. Women Only:**
**Are you pregnant or think you may be pregnant? ____Yes ____No**
**Are you taking birth control? ____Yes ____No**
**Are you nursing? ____Yes ____No**

**Please indicate which of the following applies to you. Check if answer is YES:**

| | | | |
|---|---|---|---|
| **___High Blood Pressure** | **___Low Blood Pressure** | **___Heart Attack** | **___Rheumatic Fever** |
| **___Any Heart Ailments** | **___Fainting** | **___Asthma** | **___Epilepsy/Seizures** |
| **___Cardiac Defibrillator** | **___Cardiac Pacemaker** | **___Respiratory Problems** | **___Diabetes** |
| **___ Anemia** | **___Cancer** | **___Stroke** | **___Joint Replacement or Implant** |
| **___Any Bleeding Tendency** | **___Tuberculosis** | **___Radiation Therapy to Head/Neck** | |
| **___Liver Disease** | **___Kidney Disease** | **___Aids or HIV Infection** | |
| **___Thyroid Problem** | **___Stomach Troubles/Ulcer** | **___Hepatitis/Jaundice** | |

**Please list any other medical problems not listed and extra information about above ailments: _____**
**_____**

**DENTAL HISTORY**

**Date of last dental visit: _____** **How often do you brush your teeth? _____**
**Please check, if applicable:**

| | |
|---|---|
| **___Do you feel pain in any of your teeth?** | **___Do your gums bleed while brushing or flossing?** |
| **___Are your teeth sensitive to hot/cold liquids or foods?** | **___Are your teeth sensitive to sweet or sour?** |
| **___Do you have any sores or lumps in or near your mouth?** | **___Have you had any head, neck or jaw injuries?** |
| **___Do you have frequent headaches?** | **___Do you clench or grind your teeth?** |
| **___Do you bite your lips or cheeks, frequently?** | **___Have you ever had any difficult extractions in the past?** |
| **___Have you had any orthodontic work?** | **___Have you ever had prolonged bleeding after extractions?** |
| **___Have you ever had instruction on brushing and flossing?** | **___Have you ever been treated for periodontal disease (deep clean)?** |
| **___Do you have any loose teeth?** | **___ Does dental treatment make you nervous?** |

**Have you ever experienced any of the following problems in your jaw?**
**____Clicking ____Difficulty in opening or closing ___Pain(joint, ear, side of face) ___Difficulty in chewing**

**___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 of patient, parent, or guardian (responsible party):**

**_____ Date:_____**

**Relationship to Patient:_____**