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PATIENT INFORMATION

PLEASE PRINT

Patient Name: _____ Date: _____
Last First MI

Sex: ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (H): (____) _____ (W): (____) _____ Ext: _____ (Cell): _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ S

Home Address: _____
Street Apartment #

_____
City State Zip Code

E-mail address: _____

If patient is a minor please indicate Parent or Guardian full name: _____

Who may we contact in the case of an emergency? _____ Relation _____

Emergency contact Phone (H) _____ (W): _____ (Cell): _____

EMPLOYMENT INFORMATION

Patient

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

RESPONSIBLE PARTY INFORMATION

If other than the patient

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

INSURANCE INFORMATION

Primary Coverage

Name of Insured: _____ Is insured a patient? Yes ☐ No ☐
Last First MI

Insured's Birth Date: _____ SS #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name, Claim Mailing Address and Phone Number: _____

_____

_____

Secondary Coverage

Name of Insured: _____ Is insured a patient? Yes ☐ No ☐
Last First MI

Insured's Birth Date: _____ SS #: _____ Group #:_____

Insured's Address:_____
Street City State Zip Code

Insured's Employer Name:_____

Address:_____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name, Claim Mailing Address and Phone Number:_____

_____

_____

HEATLTH INFORMATION

- Are you now under the care of a physician? Yes ☐ No ☐ **If yes, please explain below:**

_____

_____

- When did you last visit your physician? _____ Reason_____
- Name of Physician: _____Phone:_____
- If you are currently taking medication (Prescription and/or Over the Counter) please list them below and the condition/reason for which you are taking the medication(s).
(Use the back of this form if needed)

- Have you been admitted to a hospital or needed emergency care during the past two years? Yes ☐ No ☐
If yes, please explain:_____
- Have you had any radiological diagnostic x-rays in the last five years?..... Yes ☐ No ☐
- Have you ever had any Blood Transfusions?..... Yes ☐ No ☐
- Are you currently trying to modify your weight?.....Yes ☐ No ☐
- Do you take any medications to help modify/maintain your weight?.....Yes ☐ No ☐
- Do you smoke cigarettes? ☐ Yes ☐ No How many per Day? _____
- Do you consume alcohol on a daily basis?..... Yes ☐ No ☐
- Is your blood pressure ☐ Normal ☐ Low ☐ High
- Have you experienced any recent weight change?..... Yes ☐ No ☐
- Women: Are you pregnant? ☐ Yes ☐ No How long?_____
- Do you have a history of cold sores, fever blisters, or canker sores?.....Yes ☐ No ☐
- Are you being treated with immunosuppressive drugs?.....Yes ☐ No ☐
- Do you have any health problems that need further clarification? (use the back of this form if needed).....Yes ☐ No ☐

Do you now have or have you ever had any of the following? Please check all those that apply:

☐ Anesthetic Allergy
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Seasonal Allergies
☐ Allergies: Other _____
☐ Anemia
☐ Arthritis
☐ Artificial Joint Limbs/Valves
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ AIDS
☐ Dizziness
☐ Epilepsy/Seizures
☐ Excessive/Prolonged Bleeding
☐ Head Injuries
☐ Mitral Valve Prolapse
☐ Latex Allergy
☐ Prolonged Sore Throat
☐ Chronic Fatigue
☐ Childhood Heart Murmur
☐ Enlarged Lymph Nodes
☐ Night Sweats
☐ Persistent Cough/Fever
☐ Pacemaker
☐ Radiation Therapy
☐ Require Premedication
☐ High Cholesterol
☐ Sinusitis
☐ Leukemia
☐ Blood Disease
☐ Skin Condition
☐ Congenital Heart Defect
☐ Psychiatric Condition
☐ Heart Murmur
☐ Thyroid Condition
☐ Postural Hypotension
☐ Tuberculosis
☐ Hives
☐ High Blood Pressure
☐ Rheumatic Fever
☐ Hepatitis
☐ Stroke
☐ Excessive Thirst
☐ Excessive Urination
☐ Chest Pains/ Angina
☐ Bruise Easily
☐ Other_____

DENTAL INFORMATION

- When was your last dental visit?_____
- Have you ever had any serious problems associated with previous dental treatment? Yes ☐ No ☐ _____
- If yes, please explain._____
- How often do you brush your teeth?_____
- How often do you floss your teeth?_____
- Do you routinely use a mouth rinse? ☐ Yes ☐ No What Type/Brand and how often?_____
- Do you experience dry mouth (Xerostomia)?……..Yes ☐ No ☐
- Do your gums feel tender or swollen?……..Yes ☐ No ☐
- Do your gums bleed while brushing and/or flossing?……Yes ☐ No ☐
- Do you avoid brushing any part of your mouth because of pain or sensitivity?…….....Yes ☐ No ☐
- Do you feel twinges of pain when your teeth come in contact with hot, cold, sweet, or sour?.....Yes ☐ No ☐
- Are any of your teeth sensitive to air or during chewing?.....Yes ☐ No ☐
- What texture brush do you use?.....Soft ☐ Medium ☐ Hard ☐
- Do you chew on only one side of your mouth?..... Yes ☐ No ☐
- Does food catch between your teeth?..... Yes ☐ No ☐
- Do you feel your teeth are affecting your health in any way?..... Yes ☐ No ☐
- Have you ever had professional advice in dental home care?..... Yes ☐ No ☐
- Do you clench or grind your teeth while sleeping or during the day?..... Yes ☐ No ☐
- Do your facial muscles ever feel tired?..... Yes ☐ No ☐
- Do you wear full dentures?.....Upper...☐Lower...☐.....Yes ☐ No ☐
- Do you wear partial dentures?. Upper...☐Lower...☐.....Yes ☐ No ☐
- Do you have retention problems with your full or partial dentures?.....Yes ☐ No ☐
- Do you easily gag? .....Yes ☐ No ☐
- Are you apprehensive (nervous) about your dental treatment? .....Yes ☐ No ☐
- If yes -- Have you had: .....☐Nitrous Oxide.....☐Medication prior to treatment
- Please add anything you feel is important:_____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____

To the best of my knowledge, all of the preceding answers and information provided for myself/ my child are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____

Signature of patient, parent or guardian