PATIENT INFORMATION

NAME _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PATIENT OR PARENT'S EMPLOYER _____

BUSINESS ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

IF PT IS A STUDENT, NAME OF SCHOOL _____

CITY _____ **STATE** _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

_____

CONFIDENTIAL

BIRTHDATE _____

HOME PHONE _____

CIRCLE APPROPRIATE SELECTION:

MINOR SINGLE MARRIED

DIVORCED WIDOWED SEPERATED

WORK PHONE _____

CELL PHONE _____

OTHER _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____

_____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

EMPLOYER _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

RELATIONSHIP TO PATIENT _____

HOME PHONE _____

WORK PHONE _____

CELL PHONE _____

BIRTHDATE _____

SS NUMBER _____

INSURANCE INFORMATION

NAME OF INSURED _____

INSURANCE COMPANY _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

RELATIONSHIP TO PATIENT _____

BIRTHDATE _____

SS NUMBER _____

GROUP NUMBER _____

INSURANCE PHONE _____

PATIENT NAME _____ **PAGE 2**

ADDITIONAL INSURANCE

NAME OF INSURED _____ **RELATIONSHIP TO PATIENT** _____

INSURANCE COMPANY _____ **BIRTHDATE** _____

ADDRESS _____ **SS NUMBER** _____

CITY _____ **STATE** _____ **ZIP** _____ **GROUP NUMBER** _____

INSURANCE PHONE _____

PATIENT MEDICAL HISTORY

PHYSICIAN NAME _____ **PHYSICIAN PHONE** _____

- **ARE YOU UNDER THE CARE OF A PHYSICIAN** **YES** **NO**
- **HAVE YOU BEEN HOSPITALIZED IN THE LAST FIVE YEARS** **YES** **NO**
- **ARE YOU TAKING MEDICATIONS? INCLUDING OVER THE COUNTER AND PRESCRIPTION.** **YES** **NO**
- **DO YOU USE TOBACCO?** **YES** **NO**
- **DO YOU USE ALCOHOL?** **YES** **NO**
- **DO YOU USE COCAINE OR OTHER DRUGS?** **YES** **NO**
- **DO YOU WEAR CONTACTS?** **YES** **NO**
- **DO YOU HAVE ANY ALLERGIES?** **YES** **NO**

  _____

  _____
- **HAVE YOU EVER HAD A REACTION TO ANESTHETIC?** **YES** **NO**

DATE OF LAST EXAM _____

WOMEN ONLY:

- **ARE YOU PREGNANT** _____
- **ARE YOU NURSING** _____
- **ARE YOU TAING BIRTH CONTROL PILLS** _____

EXPLAIN ABOVE: _____

_____

_____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS ABOUT YOURSELF: (***MARK ALL ANSWERS WITH A YES OR NO)***

	YES	NO		YES	NO		YES	NO
HIGH BLOOD PRESSURE	___	___	**FREQUENTLY TIRED**	___	___	**KIDNEY DISEASE**	___	___
HEART ATTACK	___	___	**ANEMIA**	___	___	**AIDS/HIV INFECTION**	___	___
RHEUMATIC FEVER	___	___	**EMPHYSEMA**	___	___	**STD'S**	___	___
SWOLLEN ANKLES	___	___	**CANCER**	___	___	**THYROID PROBLEMS**	___	___
FAINING/SEIZURES	___	___	**ARTHRITIS**	___	___	**HEPATITIS A, B OR C**	___	___
ASTHMA	___	___	**JOINT REPLACEMENT**	___	___	**ULCERS**	___	___
LOW BLOOD PRESSURE	___	___	**CHEST PAINS**	___	___	**RESPIRATORY PROBLEMS**	___	___
EPILEPSY/CONVULSIONS	___	___	**SHORT OF BREATH**	___	___	**OTHER** _____		
LEUKEMIA	___	___	**STROKE**	___	___	_____		
DIABETES	___	___	**HAY FEVER/ALLERGIES**	___	___	_____		
HEART DISEASE	___	___	**TUBERCULOSIS**	___	___	_____		
CARDIAC PACE MAKER	___	___	**RADIATION THERAPY**	___	___	_____		
HEART MURMER	___	___	**GLAUCOMA**	___	___	_____		
ANGINA	___	___	**LIVER DISEASE**	___	___			

PATIENT NAME _____ **PAGE 3**

PATIENT DENTAL HISTORY

1. **DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?** _____
2. **ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?** _____
3. **ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?** _____
4. **DO YOU FEEL PAIN IN ANY OF YOUR TEETH?** _____
5. **DO YOU HAVE ANY SORES OR LUMPS IN YOUR MOUTH?** _____
6. **HAVE YOU EVER SUFFERED TRAUMA TO YOUR FACE MOUTH OR JAW?** _____
7. **DOES YOUR JAW EVER CLICK, POP, CRACKLE OR ACHE?** _____
8. **DO YOU HAVE PAIN IN YOUR JAW JOINT, EAR OR SIDE OF THE FACE?** _____
9. **DO YOU HAVE DIFFICULTY OPENING OR CLOSING YOUR MOUTH?** _____
10. **DO YOU HAVE DIFFICULTY CHEWING?** _____
11. **DO YOU HAVE FREQUENT HEADACHES?** _____
12. **DO YOU CLENCH OR GRIND YOUR TEETH?** _____
13. **DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?** _____
14. **HAVE YOU PROBLEMS WITH PREVIOUS DENTAL WORK?** _____
15. **HAVE YOU EVER HAD BRACES?** _____
16. **HOW MANY TIMES A DAY DO YOU BRUSH YOUR TEETH?** _____
17. **HOW OFTEN DO YOU FLOSS?** _____
18. **DO YOU USE A MANUAL BRUSH OR ELECTRIC?** _____
19. **DO YOU USE ANY TYPE OF MOUTH RINSE?** _____

TELL ME WHAT YOU LIKE ABOUT YOUR SMILE: _____

_____

_____

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD THAT BE? _____

_____

_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

_____ _____
PATIENT SIGNATURE DATE

_____
PRINT NAME

_____
DENTIST SIGNATURE

_____
DATE

_____
WITNESS SIGNATURE

_____
DATE