Welcome to our office. We want to provide you with the best dental care possible. To help us meet your dental care needs, please fill out this form completely. If you have any questions, please ask.

PATIENT INFORMATION

Name:_____ Birthdate:_____

SSN #:_____ Sex: M F Email:_____

Address:_____ City:_____ St:____ Zip:_____

Phone #:_____ Cell Phone#:_____

Patient or Parent/Guardian Employer:_____ Work Phone:_____

Address:_____ City:_____ St:____ Zip:_____

Spouse or Parent/Guardian's Name and Phone #:_____

Who may we thank for referring you?:_____

Emergency Name and Phone #:_____

RESPONSIBLE PARTY

Name of Person Responsible for this Account:_____

Address:_____ Phone #:_____

Birthdate: _____ SS #:_____ Cell Phone#_____

Employer:_____ Work Phone:_____

Is this person a current patient with our office? Y N

INSURANCE INFORMATION

Name of Insured:_____ Relationship to Patient:_____

Primary Dental Insurance:_____ Group #:_____

Secondary Dental Insurance:_____ Group #:_____

Insurance Address:_____

City:_____ State:_____ Zip:_____

DENTAL HEALTH HISTORY

Name of previous dentist:_____

Date of Last Exam:_____ Office Phone #:_____

	Yes	No	Notes (office use only)
Are you apprehensive about dental treatment?			
Do you gag easily?			
Do you wear dentures or partials?			
Do you have frequent headaches?			
Do you clench or grind your teeth?			
Do you bite your lips or cheeks frequently?			
Do you feel pain to any of your teeth?			
Do your gums bleed while brushing or flossing?			
Do you have any sores or bumps in or near your mouth?			
Are your teeth sensitive to hot or cold foods/liquids?			
Are your teeth sensitive to sweet or sour foods/liquids?			
Do you take fluoride supplements?			
Do you like your smile?			
How often do you brush/floss?			
Are you having any problems with your jaw?			
Are you a habitual gum chewer or pipe smoker?			
Have you had any head, neck or jaw injuries?			
Have you had any recent surgeries?			

MEDICAL HISTORY

Physician:_____ Office Phone #:_____

Date of Last Exam:_____

Heart Problems	Yes	No
Chest Pain		
Shortness of breath		
Blood Pressure problem		
Heart murmur		
Heart valve problem		
Taking heart medication		
Rheumatic Fever		
Artificial heart valve		
Blood Problems		
Easy bruising		
Frequent nosebleeds		
Abnormal bleeding		
Blood disease (anemia)		
Ever require a blood transfusion		
Allergy Problems		
Hay fever		
Sinus problems		
Skin rashes		
Taking allergy medication		
Asthma		
Intestinal Problems		
Ulcers		
Weight loss/gain		
Special diet		
Constipation/Diarrhea		
Kidney or bladder problems		
Bone or Joint Problems		
Joint replacement (i.e. total hip, knee, pins or implants)		
Arthritis		
Back or neck pain		
Premedication required by physician/surgeon		
Are you diabetic		
Family history of diabetes		
Thirsty / mouth dry most of the time		
Urinate more than 6 times a day		
Fainting Spells, Seizures or Epilepsy		
Stroke(s)		
Thyroid problems		
Persistent cough or swollen glands		
Cancer/Tumor		
Tuberculosis or other respiratory disease		
Hepatitis, jaundice, or liver trouble		

Patient/Parent Signature:_____

Dentist Initial: _____ Date:_____

	Yes	No
Herpes / Jaundice		
HIV / AIDS		
Glaucoma		
Do you smoke?		
If so, how much		
Do you drink?		
If so, how much		

In the last 12 months, have you taken any of the following? (Y or N)

Antibiotics/Sulfa drugs	
Anticoagulants (Coumadin)	
Blood Pressure Medication	
Tranquilizers	
Insulin, Orinase or similar drug	
Aspirin	
Heart Medication	
Nitroglycerin	
Cortisone (steroids)	
Natural remedies	
Nonprescription/Supplements	

Other_____

Are you allergic, or have any adverse reactions to any of the following? (Y or N)

Local anesthetics (Novocain)	
Penicillin or other antibiotics	
Sulfa drugs	
Barbiturates, sedatives/sleeping pills	
Aspirin, Ibuprofen, Acetaminophen	
Codeine, Demerol, or other narcotics	
Reactions to metal	
Latex or rubber dam	
Other_____	

Women

Contraceptive/Hormone	
Are you pregnant?	
If so, expected due date:	
Are you nursing?	
Have you reached menopause?	
If so, do you have any symptoms?	
Other_____	