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Welcome! Thank you for selecting our dental office. To help us meet all your health care needs, please complete this form as accurately as possible.

1) PATIENT INFORMATION

Patient full name: _____ Social Security # _____

Birth Date: _____ Age: _____ Male _____ Female _____

Marital Status: Married _____ Single _____ Other _____ How did you hear about our office? _____

Address: _____ City: _____ State _____ Zip C _____

Employer : _____ Occupation: _____

Previous Dentist : _____ Previous Dentist Phone: _____

Current Physician: _____ Physician Phone #: _____

Full Time Student: _____

2) TELEPHONE & EMAIL

Home Phone: _____ Work Phone: _____ Cell # _____

Email: _____

In case of an emergency, who should we contact?

Name: _____ Relationship: _____

Home Phone: _____ Cell #: _____

3) RESPONSIBLE PARTY

Who is responsible for this patient? _____ Relationship: _____

Social Security # _____ Birth Date: _____

Address: _____ City: _____ State _____ Zip C _____

Employer: _____ Home Ph: _____ Work Ph: _____

4) INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Ins. Holder: _____ Relationship:_____

Insured's SSN : _____ Birth Date: _____

Ins. Company name: _____ Employer: _____

Group # _____ ID # _____ Ins. Phone Number _____

SECONDARY INSURANCE

Name of Ins. Holder: _____ Relationship:_____

Insured's SSN : _____ Birth Date: _____

Ins. Company name: _____ Employer: _____

Group # _____ ID # _____ Ins. Phone Number _____

5) MEDICAL HISTORY

Do you consider yourself in good medical health? ___ Yes ___ No
Do you smoke or use tobacco in any forms ___ Yes ___ No
Do you have any metal rods, pins or Orthopedic Implants? ___ Yes ___ No
Do you require to PREMEDICATE for any MEDICAL CONDITIONS? ___ Yes ___ No
Are you taking any prescription/over the counter or herbal supplemental drugs? ___ Yes ___ No
Please list all medications currently taken: _____
_____.
Have you ever taken Fosamax, Actonel, Boniva, Didronel, Skelid or any medication for Osteoporosis? ___ Yes ___ No
Do you take any Blood thinners (Aspirin, Plavix, Coumadin…)? ___ Yes ___ No
Have you ever taken Phen- Phen? ___ Yes ___ No

For Women:

Are you Pregnant? ___ Yes ___ No / Nursing? ___ Yes ___ No **** **If Pregnant, week #** _____
Do you take Birth Control Rx.? ___ Yes ___ No

Have you ever had any of the following medical problems?

Abnormal bleeding	___ Yes ___ No	High Blood Pressure	___ Yes ___ No
Alcohol/drug abuse	___ Yes ___ No	HIV/AIDS	___ Yes ___ No
Anemia	___ Yes ___ No	Kidney Problems	___ Yes ___ No
Arthritis	___ Yes ___ No	Liver Problems	___ Yes ___ No
Asthma	___ Yes ___ No	Low Blood Pressure	___ Yes ___ No
Artificial Bones/Joints/Valves	___ Yes ___ No	Lupus	___ Yes ___ No
Blood Transfusion	___ Yes ___ No	Mitral Valve Prolapse	___ Yes ___ No
Cancer/Chemo	___ Yes ___ No	Osteoporosis	___ Yes ___ No
Colitis	___ Yes ___ No	Pacemaker	___ Yes ___ No
Congenital Heart Defect	___ Yes ___ No	Psychiatric Problems	___ Yes ___ No
Diabetes	___ Yes ___ No	Radiation Treatment	___ Yes ___ No
Difficulty breathing	___ Yes ___ No	Rheumatic Fever	___ Yes ___ No
Emphysema	___ Yes ___ No	Shingles	___ Yes ___ No
Epilepsy/Seizures	___ Yes ___ No	Sickle Cell Disease	___ Yes ___ No
Glaucoma	___ Yes ___ No	Stroke	___ Yes ___ No
Heart Attack	___ Yes ___ No	Thyroid Problems	___ Yes ___ No
Heart Murmur	___ Yes ___ No	Tuberculosis	___ Yes ___ No
Heart Surgery	___ Yes ___ No	Ulcers	___ Yes ___ No
Hemophilia	___ Yes ___ No	Venereal Disease	___ Yes ___ No
Hepatitis	___ Yes ___ No	Other : _____	
Herpes/Fever Blisters	___ Yes ___ No	_____	

Are you allergic to the following:

Aspirin	___ Yes ___ No	Erythromycin	___ Yes ___ No	Tetracycline	___ Yes ___ No
Codeine	___ Yes ___ No	Latex	___ Yes ___ No	Penicillin	___ Yes ___ No

Please list any other drugs/materials that you are allergic to: _____

6) **DENTAL HISTORY**

What is the reason for your visit today? _____ Are you currently in pain? ___ Yes ___ No
Have you ever had difficulties associated with any previous Dental work? ___ Yes ___ No
Have you ever had Gum treatment? ___ Yes ___ No
Have you ever had pain in your jaw joint (TMJ/TMD)? ___ Yes ___ No
Do your gums bleed? ___ Yes ___ No
Are your teeth sensitive to hot, cold or both? ___ Yes ___ No
When was the last time you had a cleaning? _____ How many times a week do you floss? _____

I understand that the information I have given today is correct to the best of my knowledge, I also understand that this information will be held in confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ _____
Patient/ Guardian Signature Date