

**PATIENT INFORMATION**

Today's Date \_\_\_\_\_

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
 Employer: \_\_\_\_\_ Business Phone: ( ) \_\_\_\_\_  
 Soc. Sec. #: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
 E-mail \_\_\_\_\_

Have you or your family ever been seen in this office?  Yes \_\_\_\_\_  No

Sex:  Male  Female

Whom can we thank for the referral?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Other sources:  Yellow Pages  
 Other \_\_\_\_\_

**FINANCIAL INFORMATION**

***Payments are due at time of service unless arrangements are made in advance***

*Person Responsible For The Account*


Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Soc. Sec. #: \_\_\_\_\_  
 Form of Payment:  Cash  Check  Credit Card: \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

**PRIMARY INSURANCE**

**SECONDARY INSURANCE**

Name of INSURED:		Name of INSURED:	
Name of Insurance Co.:		Name of Insurance Co.:	
Address:	Date of Birth	Address:	Date of Birth
Group Number:		Group Number:	
Telephone Number:		Telephone Number:	
SS#		SS#	

 \_\_\_\_\_  
 Signed (Patient, Parent, Guardian)

Reason for Visit \_\_\_\_\_

First Visit \_\_\_\_\_

Emergency \_\_\_\_\_

If so, explain \_\_\_\_\_

**MEDICAL ALERTS**

**MEDICAL HISTORY**

Date of Last Physical Exam: \_\_\_\_\_

Are you now or have you recently been under a physician's care?  YES  NO

Reason: \_\_\_\_\_

Have you ever been a patient in a hospital or had any serious illness?

Explain: \_\_\_\_\_

Check any of the following that you have had or suspected:

- |                          |                          |                          |                          |                              |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|------------------------------|--------------------------|
| YES                      | NO                       | YES                      | NO                       | YES                          | NO                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>     | <input type="checkbox"/> |
| Arthritis                |                          | Hepatitis or Jaundice    |                          | Prolonged Bleeding           |                          |
| Rheumatic Fever          |                          | Liver Disease            |                          | Fainting Tendency            |                          |
| Heart Trouble            |                          | Cancer or Tumor          |                          | Epilepsy                     |                          |
| Heart Murmur             |                          | Tuberculosis             |                          | Thyroid Disease              |                          |
| High/Low Blood Pressure  |                          | Diabetes                 |                          | Glaucoma                     |                          |
| Chest Pain               |                          | Kidney/Bladder Trouble   |                          | Radiation Treatment          |                          |
| Stroke                   |                          | Anemia                   |                          | Mental Disorders             |                          |
| Shortness of Breath      |                          | Lung Disease             |                          | HIV or AIDS                  |                          |
| Asthma or Hay Fever      |                          | Venereal Disease         |                          | Prosthetic Joint Replacement |                          |
| Sinus Trouble            |                          | Blood Disease            |                          | Blood Transfusion            |                          |

	YES	NO
Do you feel you have bad breath (halitosis)?	___	___
Do your gums bleed when you brush?	___	___
Have you had root canal work done before?	___	___
Do you have crown, bridges, partial or full dentures?	___	___
Have you had gum surgery?	___	___
Do you have teeth implants?	___	___
Do you have chronic headaches, neck or shoulder pain?	___	___
Do you have pain in or around the ears?	___	___
Do you have trouble sleeping?	___	___
Do you clench your teeth during the day or night?	___	___
Do your jaws click/pop when you open your mouth?	___	___
Has your jaw ever locked in the open or closed position?	___	___
When was the last time you had dental x-rays taken?	___	___

Explanation or Additional Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Check any of the following that you are taking or have taken:

- Cortisone Drugs     Anticoagulants     Tranquillizers     Steroids     Blood thinners     Sedatives

Are you taking any other medication?  YES  NO If yes, explain:

Are you allergic to or do you suffer ill effects from any of the following:

- Penicillin     Codeine     Dental Anesthesia     Aspirin     Household Bleach     Other: \_\_\_\_\_

Explanation or Additional Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Women Only:** Are you pregnant?  YES  NO

If yes: How many months? \_\_\_\_\_ Are you breast feeding? \_\_\_\_\_

Are you presently taking medicine of any kind routinely?

(Birth control pills, shots, or implant, hormone therapy, etc). \_\_\_\_\_

Explain: \_\_\_\_\_

The above information is true to the best of my knowledge.

**RESPONSIBLE PARTY FOR PATIENT:**

Name and Address: \_\_\_\_\_

Signature: \_\_\_\_\_