

**Patient Information**

Name \_\_\_\_\_ Soc Sec # \_\_\_\_\_  
 Mailing address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Physical address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Divorced  
 Patient employed by \_\_\_\_\_  
 Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_  
 Notify in case of emergency \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Mobile Phone \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Email \_\_\_\_\_

**Primary Insurance** *If we will be able to scan your insurance card during your visit, you can skip this part*

Person responsible for account \_\_\_\_\_  
 Relation to patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc Sec # \_\_\_\_\_  
 Person responsible employed by \_\_\_\_\_  
 Insurance company \_\_\_\_\_  
 Patient ID # \_\_\_\_\_ Group # \_\_\_\_\_

Is there a secondary insurance?  Yes  No *If yes, see the front desk*

**Dental History**

What would you like us to do today? \_\_\_\_\_  
 Are you in dental discomfort today? \_\_\_\_\_  
 Former dentist \_\_\_\_\_  
 Dentist's city and state \_\_\_\_\_  
 Dentist's phone \_\_\_\_\_  
 Date of last dental care \_\_\_\_\_ Last X-rays \_\_\_\_\_  
 How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_  
 How do you feel with the appearance of your teeth? \_\_\_\_\_  
 Other information about your dental health or previous treatment:  
 \_\_\_\_\_  
 \_\_\_\_\_

Check yes or no for the following:	
Bad breath.....	<input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding gums.....	<input type="checkbox"/> Y <input type="checkbox"/> N
Clicking or popping jaw.....	<input type="checkbox"/> Y <input type="checkbox"/> N
Food collection between teeth...	<input type="checkbox"/> Y <input type="checkbox"/> N
Grinding or clenching teeth.....	<input type="checkbox"/> Y <input type="checkbox"/> N
Loose/broken teeth.....	<input type="checkbox"/> Y <input type="checkbox"/> N
Periodontal treatment.....	<input type="checkbox"/> Y <input type="checkbox"/> N
Sensitivity to cold.....	<input type="checkbox"/> Y <input type="checkbox"/> N
Sensitivity to hot.....	<input type="checkbox"/> Y <input type="checkbox"/> N
Sensitivity to sweets.....	<input type="checkbox"/> Y <input type="checkbox"/> N
Sensitivity when biting.....	<input type="checkbox"/> Y <input type="checkbox"/> N
Sores or growths in mouth.....	<input type="checkbox"/> Y <input type="checkbox"/> N

**Medical History**

Physician's name \_\_\_\_\_

Phone \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you had any serious illness or operations?.....  Y  N

If yes, describe:

Are you currently under physician care?.....  Y  N

If yes, describe:

Have you ever had a blood transfusion?.....  Y  N

If yes, give approximate dates:

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel, and Boniva.  Y  N

**Women** Are you pregnant?.....  Y  N

Nursing?.....  Y  N

Taking birth control pills?...  Y  N

List all medications the patient currently taking: \_\_\_\_\_

\_\_\_\_\_

List all the patient's drug allergies \_\_\_\_\_

\_\_\_\_\_

List all patient's other allergies \_\_\_\_\_

\_\_\_\_\_

**Authorization**

I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the us of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Check yes or no for the following:

- AIDS/HIV.....  Y  N
- Anaphylaxis.....  Y  N
- Anemia.....  Y  N
- Arthritis, Rheumatism.....  Y  N
- Artificial joints.....  Y  N
- Asthma.....  Y  N
- Back problems.....  Y  N
- Blood disease.....  Y  N
- Cancer.....  Y  N
- Chemical dependency.....  Y  N
- Chemotherapy.....  Y  N
- Cough, persistent.....  Y  N
- Diabetes.....  Y  N
- Epilepsy.....  Y  N
- Fainting.....  Y  N
- Heart murmur.....  Y  N
- Heart problems.....  Y  N
- If yes, describe:
- Hemophilia/Abnormal bleeding.....  Y  N
- Herpes.....  Y  N
- Hepatitis.....  Y  N
- High blood pressure.....  Y  N
- Jaw pain.....  Y  N
- Kidney disease or malfunction.....  Y  N
- Liver disease.....  Y  N
- Material allergies (latex, wool, chemicals.).....  Y  N
- Nervous problems.....  Y  N
- Radiation treatment.....  Y  N
- Respiratory disease.....  Y  N
- Rheumatic/Scarlet fever.....  Y  N
- Shortness of breath.....  Y  N
- Stroke.....  Y  N
- Surgical implant.....  Y  N
- Thyroid disease or malfunction.....  Y  N
- Tobacco habit.....  Y  N
- Tuberculosis.....  Y  N
- Ulcer/Colitis.....  Y  N
- Cold Sores.....  Y  N