

PATIENT INFORMATION

Date: _____

Name:				Date of Birth:	
Last	First	Middle	Preferred		
Home Phone: () ()		Work Phone: () ()		Cell Phone:	
				<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Child <input type="checkbox"/> Other	
Address:					
Street		Apt. #	City	State	Zip Code
Employer:		Occupation:		SSN:	
How did you hear about our practice?					
Emergency Contact:				Home Phone:	
Name		Relationship:		() ()	
				Work Phone:	

HEALTH INFORMATION

Physician Name:	City/ State:	Phone: () ()	Do you, or have used, any form of tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last visit:			Reason For visit:	
			For women: Are you, or could you be pregnant?	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			Have you ever taken a bisphosphonate medication for osteoporosis?	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you been admitted to a hospital or needed emergency care during the past 5 years?			Are you allergic to, or had an adverse reaction for any of the following? (please circle)	
If yes, please explain: <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No LATEX ASPIRIN PENICILLIN ERYTHROMYCIN	
Are you now under the care of a physician?			Please list any other medication or substance that you are allergic to:	
If yes, please explain: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you have any current health problems?				
If yes, please explain: <input type="checkbox"/> Yes <input type="checkbox"/> No				

Are you currently taking any medications? If yes, please list below:

Medication	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had or been treated by a physician for:

- Damaged Heart Valves, Mitral Valve Prolapse, or Artificial Heart Valves? Yes No
- Rheumatic Fever, Rheumatic Heart Disease, or Congenital Heart Problems? Yes No
- Have you ever been advised to pre-medicate prior to dental treatment? Yes No
- Artificial Joints/Replacements? Yes No
- High Blood Pressure? Yes No
- Cancer, Tumors, or Growths? Yes No
- AIDS, AIDS related conditions, or tested HIV positive? Yes No
- Diabetes? Yes No

Circle any conditions listed below that you have, or have had:

- | | | | |
|----------------|-------------------|------------------|-------------------|
| Alcoholism | Chemotherapy | Hepatitis A | Radiation Therapy |
| Anemia | Emphysema | Hepatitis B | Sinus Problems |
| Angina | Epilepsy/Seizures | Kidney Disease | Stroke |
| Arthritis | Fainting | Liver Disease | Thyroid Disease |
| Asthma | Glaucoma | Mental Disorders | Tuberculosis (TB) |
| Blood Disorder | Hay Fever | Pacemaker | Ulcers |

Provider notes: _____

DENTAL INFORMATION

When was your last dental visit?	Name of Previous Dentist:
What is your main dental concern?	City/ State: Phone: ()
Have you had dental x-rays taken within the past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Are your teeth sensitive to hot, cold, sweets, or biting pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Would you like your smile to look better or different? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Are you aware of grinding or clenching your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Do you have pain in your jaw joints or have frequent headaches? Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Have you ever had any injuries to your teeth or jaws? Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Have you ever had braces on your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Have you ever been treated for gum disease or had periodontal surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Are you anxious or fearful about dental visits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know If yes, please explain: How often do you brush? How often do you use dental floss?	
Provider notes: _____	

INSURANCE INFORMATION

Name of Insured:			Insured's Birth Date:		
Last	First	Middle			
SSN #:	INS ID #:	Group #:	Patient's relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
Insured's Address:					
Street	Apt. #	City	State	Zip Code	
Insured's Employer Name:			Insurance Company Name:		Phone: ()
Insured's Employer Address:			Insurance Company Address:		
Street	Apt. #	Street			
City	State	Zip Code	City	State	Zip Code

CONSENT FOR SERVICES

- To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health I will inform the doctor at the next appointment.
- I authorize the release of any medical information necessary to process claims.
- I understand that I am personally responsible for all professional fees at the time service is rendered. In the event of default, the undersigned agrees to pay all costs of collection including any reasonable attorney's fees and court costs.

_____ Date:

Signature of patient, parent or guardian _____

If parent/guardian, please print name

Relationship _____