PATIENT INFORMATION

Patient Name: ____ Date: ____________
Last First Middle Initial (Preferred Name)

Gender: Male Female (Circle One) Family Status: Married Single Child Other: _______________ (Circle One)

Birth Date: _______________ Social Security Number: _____-_____-_____

Phone (Home): _____________ (Work): _____________ (Cell): _____________ Best Time To Call: _______

Address: ____
Street City State Zip Code

Drivers License Number: _________________ E-Mail Address: _________________________

Emergency Contact: ____
Name Phone Number Relationship To You

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? _______________________________

INSURANCE SUBSCRIBER INFORMATION

Name: ____

Patient's Relationship to Subscriber: (Circle One) Self Spouse Child Other: _______________

Insurance Company Name: ____

Subscriber's Birth Date: _____________ Social Security Number: _____-_____-_____ or Subscriber ID # _______________

EMPLOYMENT INFORMATION

The following is for: ☐ The Insurance Subscriber ☐ The Person Responsible For Payment

Employer Name: _____________________________ Occupation: _____________________

Address: ____
Street City State Zip Code

Phone Number: _____________________

DENTAL HISTORY

Prior Dentist's name, address, and phone number: ____

When was your last visit to the dentist? ____

What is the reason for your dental visit today?____

How frequently do you brush your teeth? ☐ 3(+) a day ☐ Twice a day ☐ Once a day ☐ Weekly ☐ Seldom

How frequently do you floss your teeth? ☐ 1(+) a day ☐ 2-6 weekly ☐ 1-6 monthly ☐ Seldom ☐ Never

If you could change anything about your mouth, teeth, or smile, what would it be? ______________________

Have you ever had any complications or severe reactions to dental treatment or local anesthetics? **Yes No**

If yes, please explain: ____

Please mark any of the following to indicate **Yes** in response to the questions:

- ☐ Are any of your teeth currently causing you pain?
- ☐ Do your gums bleed when you brush or floss?
- ☐ Are your teeth sensitive to hot or cold?
- ☐ Do you grind your teeth (consciously or during sleep)?
- ☐ Do you have any loose teeth?
- ☐ Have you ever been diagnosed with periodontal (gum) disease?
- ☐ Do you currently have dental implants, dentures, or partials?
- ☐ Do you snore or gasp while sleeping?

If any of the previous questions are marked, please explain: ____

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MEDICAL HISTORY

Primary Care Physician Name: ________________________________ Phone Number: ________________

Would you consider yourself to be in fairly good health? **Yes No**

If no, please explain: ____

What is the date (or approximate date) of your last medical exam? ______________________

Within the past year, have there been any changes in your general health? **Yes No**

If yes, please explain: ____

Are you currently under the care of a physician due to a specific condition? **Yes No**

If yes, what is the condition being treated? ____

Have you been hospitalized within the last 5 years due to a surgery or illness? **Yes No**

If yes, please explain: ____

Have you had any illnesses or surgeries that we need to be aware of? **Yes No**

If yes, please explain: ____

Are you currently taking any prescription or non-prescription medications? **Yes No**

If yes, please list: ____

Have you ever been told by a physician or dentist that you need to take pre-medication antibiotics? **Yes No**

If yes, please list what you were prescribed: ____

Have you ever had or experienced any of the following? Please check those that apply:

☐ Allergy - Aspirin	☐ Allergy - Codeine	☐ Allergy - Erythromycin	☐ Allergy - Hay Fever	☐ Allergy - Latex
☐ Allergy - Penicillin	☐ Allergy - Sulfa	☐ Allergy - Other	☐ Anemia	☐ Arthritis
☐ Artificial Joints	☐ Asthma	☐ Blood Disease	☐ Cancer	☐ Diabetes
☐ Dizziness	☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting	☐ Glaucoma
☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure
☐ HIV	☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorder
☐ Nervous Disorders	☐ Pacemaker	☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Rheumatism	☐ Sinus Problems	☐ Stomach Problems	☐ Stroke	☐ Thyroid Disease
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Venereal Disease	☐ Other

If any apply, please explain: ____

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Do you have any other conditions, diseases, etc. not listed above? **Yes No**

If yes, please explain: ____

Do you smoke or use smokeless tobacco? **Yes No** If yes, how much and how often? ______________________

Do you drink alcohol? **Yes No** If yes, how often? ________________________________

Have you ever had any drug addictions? **Yes No** If yes, please explain: ______________________

Have you taken Phen-Fen or similar appetite suppressants? **Yes No** If yes, please explain: ______________

Have you taken Cortisone/Steroid Medications? **Yes No** If yes, please explain: ______________________

Have you ever taken bisphosphonates such as Fosamax, Boniva, Actonel, Aredia, Bonefos, Digronel, Zometa, or any other drugs prescribed to decrease bone resorption? **Yes No** If yes, please explain: ______________________

WOMEN ONLY

Are you pregnant? **Yes No** If yes, when is your due date? ______________________

Are you currently using birth control? **Yes No** If yes, what are you using? ______________________

Please bring your insurance card and driver's license to the front desk, along with your completed forms where you will electronically sign them.