

Patient Information

Patient's Name:			Date:		
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Child <input type="checkbox"/> Other		Social Security #:		
Email:			Birth Date:		
Phone (Home):		(work):	Ext:	(Cell):	
Street Address:			City and State:		Zip code:

Patient Employment Information

Employer Name:		Occupation:		How long:	
Street Address:				City and State:	
Zip Code:		Phone:			

Emergency Contact

Emergency Contact:		Phone:
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Insurance Information

Primary Insurance Company Name:			ID #:		Group #:
Insured's Employer:		Insured's Birth Date:		Insurance Company Phone:	
Insurance Company Address (Street):				(City,State,zip):	
Name of insured (Last,First,MI):			Patient's Relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
Secondary Insurance Company Name:			ID #:		Group #:
Insured's Employer:		Insured's Birth Date:		Insurance Company Phone:	
Insurance Company Address (Street):				(City,State,zip):	
Name of Insured (Last,First,MI):			Patient's Relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		

Responsible Party Information (If other than patient, must be present to sign)

Name:		Social Security #:		DOB:	
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Child <input type="checkbox"/> Other		Email:		
Phone (Home):		Work:	Ext:	(Cell):	
Address (Street, City, State, Zip):					

Referral Information

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

Patient Name:	Date:
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Health Information

Date of Last Dental Visit:	Reason for the visit:
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What would you like us to do today?	Are you in discomfort today? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Former Dentist:	Phone:
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Have you had any recent problems with any of the following? Please check yes or no:

<input type="checkbox"/> Y <input type="checkbox"/> N Bad Breath	<input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth	<input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth
<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets	<input type="checkbox"/> Y <input type="checkbox"/> N Bleeding Gums	<input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth
<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 Clicking or popping jaw
<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings		

How often do you brush?	Floss?
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How do you feel about the appearance of your teeth?

Have you ever experienced an adverse reaction during or in conjunction with medical or dental procedure? Yes No

Other information about your dental health or previous treatment:

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

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Chem. Dependency	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Allergies:	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Periodontal Treatment
<input type="checkbox"/> Codeine Allergy	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pregnancy/Due Date: _____
<input type="checkbox"/> Latex/Rubber Allergy	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Pre-med: _____
<input type="checkbox"/> Metal Allergy	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Penicillin Allergy	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Sulfa Allergy	<input type="checkbox"/> Fainting/Dizziness	<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Tylenol Allergy	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Arthritis/Rheumatism	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tobacco Use
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Artificial Valves	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Tumors
<input type="checkbox"/> Asthma	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other: _____

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel, and Boniva. Yes No

Have you ever had any complications following dental treatment? Yes No
If yes, please explain:

Have you been admitted to a hospital, had any surgeries or needed emergency care during the past two years? Yes No
If yes, please explain:

Are you now under the care of a physician? Yes No
If yes, please explain:

Name of Physician:	Phone:
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Are you taking ANY medications, pills, vitamins/supplements or drugs? Yes No
If yes, please List: _____

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 without fail.

Date: _____

Signature of patient, parent or guardian