PATIENT INFORMATION

NAME ______ DATE OF BIRTH ______ TODAY'S DATE ______

HOME ADDRESS ______ CITY ______ STATE ______ ZIP ______

HOME PHONE ______ BUSINESS PHONE OR CELL PHONE # ______

DRIVER'S LICENSE # ______ PATIENT SS# ______

RESPONSIBLE PARTY INFORMATION

NAME ______
Last First Initial

RELATIONSHIP TO PATIENT
☐ SELF ☐ PARENT
☐ SPOUSE ☐ OTHER ______

MARITAL STATUS
SINGLE ☐ MARRIED ☐
DIVORCED ☐ WIDOWED ☐
SEPARATED ☐

DRIVER'S LICENSE # ______ HOME PHONE # ______

ADDRESS ______ CELL PHONE# ______

MAILING ADDRESS ______ WORK PHONE # ______

HOW LONG AT THIS ADDRESS? ______ OWN ______ RENT ______ HOME

SOCIAL SECURITY # ______ BIRTH DATE ______

EMPLOYER ______ OCCUPATION ______ NO. YRS EMPLOYED ______

SPOUSE NAME ______ SOCIAL SECURITY # ______ BIRTH DATE ______

SPOUSE EMPLOYER ______ OCCUPATION ______ WORK PHONE # ______

CELL PHONE # ______

EMERGENCY CONTACT NAME ______ TELEPHONE # ______

ADDRESS ______ CELL PHONE # ______

DENTAL INSURANCE INFORMATION

INSURED NAME ______ SOCIAL SECURITY # ______

INSURANCE COMPANY ______ GROUP # ______ ID # ______

INSURANCE COMPANY ADDRESS ______

DO YOU HAVE DUAL COVERAGE ______ YES ______ NO

IF YES, INSURANCE COMPANY ______ GROUP # ______

INSURANCE COMPANY ADDRESS ______

IN THE EVENT MY INSURANCE COMPANY ISSUES ME THE PAYMENT, I WILL BRING THE INSURANCE CHECK AND ALL PAPERWORK TO THIS DENTAL OFFICE.

X ______

MEDICAL INFORMATION

HOW LONG SINCE YOUR LAST COMPLETE MEDICAL EXAMINATION? ______

ARE YOU UNDER A PHYSICIAN'S CARE NOW? ______

IF SO, FOR WHAT CONDITION? ______

PHYSICIAN'S NAME AND ADDRESS ______ PHONE ______

ARE YOU PRESENTLY TAKING ANY DRUGS OR MEDICATIONS? IF SO LIST. ______

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING: PLEASE CHECK

	YES	NO		YES	NO		YES	NO
a. RHEUMATIC FEVER			i. TUBERCULOSIS			q. CHEMOTHERAPY		
b. HEART TROUBLE OR MURMUR			j. EPILEPSY			r. RADIATION THERAPY		
c. HIGH OR LOW BLOOD PRESSURE			k. KIDNEY PROBLEMS			s. ARTIFICIAL JOINT OR PROSTHESIS		
d. STROKE			l. LIVER PROBLEMS			t. ALLERGIC TO SULFITES		
e. SINUS TROUBLE			m. HYPOGLYCEMIA (LOW BLOOD SUGAR)			(FOOD PRESERVATIVE)		
f. DIABETES			n. ASTHMA			u. ALLERGY TO LATEX		
g. HEPATITIS (JAUNDICE)			o. ARTHRITIS			v. ANY OTHER MEDICAL PROBLEM		
h. A.I.D.S.			p. TUMOR OR GROWTH					

HAVE YOU HAD ABNORMAL BLEEDING DUE TO EXTRACTIONS, SURGERY OR TRAUMA? ______

ARE YOU TAKING ANY BLOOD THINNERS? ______

ARE YOU TAKING OR HAVE YOU EVER TAKEN ANY BONE DENSITY MEDICATION SUCH AS FOSAMAX, BONIVA, RECLAST, ETC. ______

ARE YOU ALLERGIC TO OR REACT ADVERSELY TO ANY DRUGS OR MEDICATION? ______

IF SO, WHICH? ______

WOMEN - ARE YOU PREGNANT? ______

DO YOU USE ANY TOBACCO PRODUCTS? ______

DO YOU HAVE ANY FEAR OF HAVING DENTAL WORK DONE? ______

HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WITH DENTAL TREATMENT? ______

IF SO, WHAT? ______

HAVE YOU HAD NITROUS OXIDE GAS FOR DENTAL WORK? ______

DO YOUR GUMS EVER BLEED? ______ ARE YOU TROUBLED WITH BAD BREATH? ______ ARE ANY TEETH SENSITIVE TO HOT, COLD, SWEETS OR PRESSURE? ______

DO YOU HAVE FREQUENT HEADACHES? ______ DO YOU GRIND OR CLINCH YOUR TEETH? ______ DO YOUR JAWS FEEL TIRED UPON AWAKENING EACH DAY? ______

HAVE YOU NOTICED A CLICKING OR POPPING SOUND NEAR YOUR EAR UPON OPENING OR CLOSING YOUR MOUTH? ______

HOW DO YOU CLEAN YOUR MOUTH? ______

ARE YOU SATISFIED WITH YOUR PAST DENTISTRY? ______

IF NOT, WHY? ______

HOW DO YOU FEEL YOUR TEETH LOOK? ______

______

WHEN WAS YOUR LAST DENTAL EXAMINATION? ______ PREVIOUS DENTIST ______

WHAT DO YOU FEEL MAY NEED TO BE DONE AT THIS TIME? ______

REFERRED BY ______

PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED UNLESS PAYMENT ARRANGEMENTS HAVE BEEN APPROVED IN ADVANCE BY OUR STAFF. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, DISCOVER OR CARE CREDIT. WE WILL BE HAPPY TO HELP YOU PROCESS YOUR INSURANCE CLAIM-FORM. IF YOU HAVE ANY QUESTIONS ABOUT THE ABOVE INFORMATION OR ANY UNCERTAINTY REGARDING INSURANCE COVERAGE, PLEASE DO NOT HESITATE TO ASK US. WE ARE HERE TO HELP YOU.

I CERTIFY THAT THE INFORMATION LISTED IS COMPLETE & ACCURATE

______

SIGNATURE
(PATIENT, PARENT OR GUARDIAN)

MEDICAL HISTORY UPDATE	COMMENTS	INITIALS
DATE		

MEDICAL HISTORY UPDATE	COMMENTS	INITIALS
DATE		