Patient Information

*Date

*SS / HIC / Patient ID #

* Patient Name (Last Name, First Name, Middle Name)

*Address

*Email

State

Zip

Sex

M F

Birthdate

*Age

Married Widowed Single Minor Separated
Divorced Partnered for

Years

Patient Employer / School

Occupation

Employer / School Address

Patient Employer / Phone

Spouse's Name

Birthdate

SS#

Spouse's Employer

Whom may we thank for referring you?

Dental Insurance

Who is responsible for this account?

*Relationship to Patient

*Insurance Co.

*Group #

Is Patient Covered by additional insurance?

Yes No

Subscriber Name

*Birthdate

*SS#

Relationship to Patient

*Insurance Co.

*Group #

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to

Dr.
If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named dentist may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the gate signed below.

PHONE NUMBERS

Phone

Work

Fxt

Alt. Phone

Spouse's Work

Best Time and Place to Reach You

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name

Relationship

Emegency Contact Number

Work Phone

DENTAL HISTORY

Reason for today's visit

Former Dentist

*City / State

*Date of Last Dental Visit

*Date of Last Dental X-rays

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath
Yes No

Bleeding Gums
Yes No

Blisters on lips or mouth
Yes No

Burning sensation on tongue
Yes No

Chew on one side of mouth
Yes No

Cigarette, pipe, or cigar smoking
Yes No

Clicking or popping jaw
Yes No

Dry mouth
Yes No

Fingernail biting
Yes No

Food collection between the teeth
Yes No

Foreign objects
Yes No

Grinding teeth
Yes No

Gums swollen or tendor
Yes No

Jaw pain or tiredness
Yes No

Lip or cheek biting
Yes No

Loose tooth or broken fillings
Yes No

Mouth breathing
Yes No

Mouth pain, brushing
Yes No

Orthodontic treatment
Yes No

Pain around ear
Yes No

Periodontal treatment
Yes No

Sensitivity to cold
Yes No

Sensitivity to heat

Yes No

Sensitivity to sweets
Yes No

Sensitivity when biting
Yes No

Sores or growths in your mouth
Yes No

How often do you floss?

How often do you brush?

HEALTH HISTORY

Physician's Name

Date of Last Visit

Have you ever used a bisphosphonate? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.
Yes No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (doxfonfluramine).

Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV
Yes No

Epilepsy
Yes No

Respiratory Disease
Yes No

Anemia
Yes No

Fainting or dizziness
Yes No

Rheumatic Fever
Yes No

Arthritis, Rheumatism
Yes No

Glaucoma
Yes No

Scarlet Fever
Yes No

Artificial Heart Valvos
Yes No

Headaches
Yes No

Shortness of Breath
Yes No

Artificial Joints
Yes No

Heart Murmur
Yes No

Sinus Trouble
Yes No

Asthma
Yes No

Heart Problems
Yes No

Skin Rash
Yes No

Back Problems
Yes No

Hepatitis Type
Yes No

Special Diet
Yes No

Bleeding abnormally, with extractions or surgery
Yes No

Herpes
Yes No

Stroke
Yes No

Blood Disease
Yes No

High Blood Pressure
Yes No

Swollen Feet or Ankles
Yes No

Cancer
Yes No

Jaundice
Yes No

Swolen Neck Glands
Yes No

Chemical Dependency
Yes No

Thyroid Problems
Yes No

Kidney Disease
Yes No

Circulatory Problems
Yes No

Tuberculosis
Yes No

Low Blood Pressure
Yes No

Cortisone Treatments
Yes No

Ulcer
Yes No

Nervous Problems
Yes No

Diabetes
Yes No

Weight Loss, unexplained
Yes No

Psychiatric Care
Yes No

Radiation Treatment
Yes No

Jaw Pain
Yes No

Chemotherapy
Yes No

Tonsillitis
Yes No

Liver Disease
Yes No

Congenital Heart Lasions
Yes No

Tumor or growth on head or neck
Yes No

Mitral Valve Prolapsa
Yes No

Cough, persistent or bloody
Yes No

Venereal Disease
Yes No

Pacemaker
Yes No

Emphysama
Yes No

Do you wear contact lenses?
Yes No

WOMEN:

Are you pregnant?
Yes No

Due Date

Are you nursing?
Yes No

Taking birth control pills?
Yes No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

Current Medications

Pharmacy Name

Pharmacy Phone

ALLERGIES

Aspirin Barbiturates (Sleeping Pills) Codeine Iodine Latex New Option Penicillin Sulfa

Other