Date_______________

PATIENT INFORMATION

Name____ Home Phone_________________

Referred By______________________ Social Security #____________________________ Birthdate_________________

Address____ Cell Phone___________________

City____________________ State_______ Zip___________ Email____

Sex: ☐M ☐F ☐Minor ☐Single ☐Married ☐Long-Term Partner ☐Divorced ☐Widowed ☐Separated

Employer____ Business Phone___________________

Emergency Contact______________________________ Phone #__________________ Relation____________________

PRIMARY INSURANCE

Policy Holder ____ Relationship: ☐Self ☐Spouse ☐Parent

Policy Holder Birthdate_________________ Social Security #____________________________

Address____ Cell Phone___________________

City____________________ State____________ Zip___________

Employer______________________________________ Insurance Company_______________________________________

Subscriber ID # ________________________________ Group #___________

ADDITIONAL INSURANCE

Policy Holder ____ Relationship: ☐Self ☐Spouse ☐Parent

Policy Holder Birthdate_________________ Social Security #____________________________

Address____ Cell Phone___________________

City____________________ State____________ Zip___________

Employer______________________________________ Insurance Company_______________________________________

Subscriber ID # ________________________________ Group #___________

DENTAL HISTORY

Former Dentist_______________________________ Date of Last X-rays_________________________

City, State__________________________________ How Often Do You Floss?___________________ ☐ Manual ☐ WaterPik/Air Flosser

Date of Last Dental Visit______________________ How Often Do You Brush?___________________ ☐ Manual ☐ Electric

Please check all that apply:

☐ Bad Breath
☐ Bleeding Gums
☐ Blisters on Lips or Mouth
☐ Fingernail Biting
☐ Grinding Teeth
☐ Lip or Cheek Biting
☐ Loose Teeth or Broken Fillings
☐ Orthodontic Treatment
☐ Pain Around Ear
☐ Periodontal Treatment
☐ Sensitivity to Cold
☐ Sensitivity to Heat
☐ Sensitivity to Sweets
☐ Sensitivity When Biting
☐ Frequent Headaches
☐ Jaw, Head or Neck Injuries
☐ Jaw Difficulty: Clicking and/or Pain
☐ Tooth Pain
☐ Sensitivity Toothpaste
☐ Use Mouth Wash

MEDICAL HISTORY

Physicians Name____ Last Visit______________________

1. Are you currently under medical treatment? ☐ Yes ☐ No
2. Have you had any serious illnesses or operations? ☐ Yes ☐ No
3. Are you taking any medication? ☐ Yes ☐ No
   Please list medication__________________________________
   ____
4. Do you smoke, use chewing tobacco? ☐ Yes ☐ No
5. Do you drink alcohol, or use any recreational drugs? ☐ Yes ☐ No
6. Do you wear contact lenses? ☐ Yes ☐ No
   Are you any of the following ☐ Pregnant ☐ Nursing ☐ Taking birth control pills

7. Have you had an allergic reaction to the following:

Local Anesthetics (eg. Novocain) ☐ Yes ☐ No
Penicillin or other Antibiotics ☐ Yes ☐ No
Sulfa Drugs ☐ Yes ☐ No
Barbiturates (sleeping pills) ☐ Yes ☐ No
Sedatives ☐ Yes ☐ No
Iodine ☐ Yes ☐ No
Aspirin ☐ Yes ☐ No
Other ☐ Yes ☐ No

Please check all that apply:

☐ AIDS	☐ Emphysema	☐ Pacemaker
☐ Anemia	☐ Epilepsy	☐ Psychiatric Care
☐ Arthritis, Rheumatism	☐ Fainting or Dizziness	☐ Radiation Treatment
☐ Artificial Heart Valves	☐ Glaucoma	☐ Respiratory Disease
☐ Artificial Joints:_______	☐ Headaches	☐ Rheumatic Fever
☐ Asthma	☐ Heart Murmur	☐ Scarlet Fever
☐ Back Problems	☐ Heart Problems	☐ Shortness of Breath
☐ Excessive Bleeding	☐ Hepatitis – Type_______	☐ Sinus Trouble
☐ Blood Disease	☐ Herpes	☐ Sleep Apnea
☐ Cancer	☐ High Blood Pressure	☐ Skin Rash
☐ Chemical Dependency	☐ HIV Positive	☐ Stroke
☐ Chemotherapy	☐ Jaundice	☐ Swelling of Feet/Ankles
☐ Chronic Fatigue Syndrome	☐ Jaw Pain	☐ Swollen Neck Glands
☐ Circulatory Problems	☐ Kidney Disease	☐ Thyroid Problems
☐ Congenital Heart Lesions	☐ Latex Sensitivity	☐ Tonsillitis
☐ Cortisone Treatments	☐ Liver Disease	☐ Tuberculosis
☐ Cough – persistent or bloody	☐ Low Blood Pressure	☐ Tumor or growth on head/neck
☐ Diabetes	☐ Mitral Valve Prolapse	☐ Ulcer
☐ Other __________________	☐ Nervous Problems	☐ Venereal Disease

SIGNATURE OF RESPONISBLE PARTY____ DATE__________________________