Patient Information

Patient Name_____
Last First M.I.

Address_____
Number & Street

_____
City State Zip

Male ☐ Female ☐

Employer_____

Employer Address_____

_____

Home Tel. # (____) _____

Work Tel. # (____) _____

Cell # (____) _____

E-mail Address_____

Social Security # _____

Date of Birth_____

Position/Job Title_____

Drivers License #_____

Spouse's Name (Parent if Minor)_____

Person to Contact in Emergency & Phone #_____

Name of Physician & Phone #_____

_____
Who may we thank for your referral?

Dental Insurance Information

Insured's Name_____
Last First MI

Insured's Address ☐ _____
x if same as above Number & Street

_____
City State Zip

Employer_____

Employer Address ☐ _____
x if same as above Number & Street

Name of Insurance_____

Relationship to Patient ☐ Spouse ☐ Parent ☐ Self

Social Security # _____

Date of Birth_____

Tel. # (____) _____

ID # _____ Group# _____

Tel. # (____) _____

Secondary Coverage

Insured's Name_____
Last First MI

Insured's Address ☐ _____
x if same as above Number & Street

_____
City State Zip

Employer_____

Employer Address ☐ _____
x if same as above Number & Street

Name of Insurance_____

Relationship to Patient ☐ Spouse ☐ Parent ☐ Self

Social Security # _____

Date of Birth_____

Tel. # (____) _____

ID # _____ Group# _____

Tel. # (____) _____

MEDICAL HISTORY

Blood Pressure _____/_____ Pulse _____ Resp. _____ **For Doctors Use**

Medical History

Do YOU have or have you had: *(Not a family member)*

Any type of artificial implant or prosthesis? (including stents, pins, plates, hip/joint replacement, breast augmentation)..... YES NO

When were they placed? _____

Any change in your health recently? Have you been hospitalized? ..... YES NO

A physical within the past year? ..... YES NO

Any serious illness or operations? ..... YES NO

If so describe _____

Do you currently take aspirin or any other blood thinner ..... YES NO

High blood pressure ..... YES NO

Ever taken any medication for osteoporosis or diseases of the bone? PLEASE LIST ..... YES NO
(ie. Fosamax, Actonel, Zometa, Reclast, Boniva, Aredia, etc.)

Heart Murmur/Mitral Valve Prolapse? ..... YES NO

Rheumatic fever or rheumatic heart disease? ..... YES NO

Cardiovascular disease (heart attack, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke?) ..... YES NO

Fainting spells or seizures? ..... YES NO

Asthma? ..... YES NO

Seasonal Allergies? ..... YES NO

Pacemaker? ..... YES NO

Are you diabetic? ..... YES NO

Any history of hepatitis? ..... YES NO

Any history of arthritis? ..... YES NO

Any history of kidney trouble? ..... YES NO

Any history of cancer? Where? _____ ..... YES NO

Any history of radiation treatment? ..... YES NO

Any history of tuberculosis? ..... YES NO

Any history of alcohol or substance abuse? ..... YES NO

Any history of Auto-Immune Disease (AIDS)? (HIV)? ..... YES NO

Any type of blood disorder? Anemia, SickleCell? ..... YES NO

Are you currently taking any medication? ..... YES NO

If so what? _____

_____

_____

Are you allergic to any medications or foods? PLEASE LIST (ie aspirin, antibiotics, codeine, local anesthetic, peanuts, fish, etc) ___

_____

Do you have any disease, condition, or problem that has not been asked? If so explain

_____

Any clicking of jaw or discomfort? ..... YES NO

Do you smoke? How much _____? ..... YES NO

WOMEN

Are you pregnant? ..... YES NO

Do you take birth control pills? ..... YES NO

Dental History

Have you noticed?

- Swollen or tender gums ☐
- Bleeding Gums ☐
- Shifting teeth ☐
- Tooth sensitivity to hot or cold ☐
- Dry mouth ☐
- Constant sore or hoarse throat ☐
- Toothaches ☐

Are you concerned about?

- Cavities? ☐
- Gum disease ☐
- Tartar build-up ☐
- Crowded teeth ☐
- Improving the appearance of your teeth ☐
- Date of last dental visit _____

*In the advent of default of payment, I will be held responsible for all reasonable collection and attorney's fees. I hereby give my consent for treatment.

x Patient Signature _____ Date _____

Doctor Signature _____ Date _____

The above given information is true to the best of my knowledge