PATIENT INFORMATION

Patient Name: _____ **Birth Date:** _____
LAST FIRST MI

☐ **Male** ☐ **Female** **Status: Married** ☐ **Single** ☐ **Child** ☐

Social Security #: _____ **Driver's Lic #:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Mailing Address:

_____
STREET / PO BOX APT. or UNIT #

_____
CITY STATE ZIP CODE

E-mail Address: _____

Who may we thank for referring you? ☐ **Family/ Friend Name:** _____

☐ **Location** ☐ **TV** ☐ **Work** ☐ **School** ☐ **Newspaper** ☐ **Radio** ☐ **Phonebook**

Responsible Party Information

Name: _____ **Birth Date:** _____
LAST FIRST MI

Social Security #: _____ **Driver's Lic #:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

E-mail Address: _____

Dental Insurance Information

NAME OF INSURANCE Co.:	PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
INSURANCE CO. PHONE #:		
GROUP NUMBER:		
ID / POLICY NUMBER:		
SUBSCRIBERS NAME:		
SUBSCRIBERS DOB:		

I authorize the use of any information necessary to process my insurance. I also authorize my insurance company(s) to issue the dental benefits of my plan directly to this office. _____

MEDICAL / DENTAL HISTORY

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____ Name of Physician:_____
- Please list any current medication you are taking: _____
- Is there any other medical or dental information you feel I should know about? ☐ Yes ☐ No
  If yes please explain:_____

Please check the following that apply to you:

- ☐ **Sensitivity (hot, cold, sweet)**
  Where: _____
- ☐ **Headaches, neck or jaw joint pain_**
- ☐ **Mouth ulcers or cold sores**
- ☐ **Grinding or clenching**
- ☐ **Bleeding swollen or irritated gums**
- ☐ **Loose, chipped or shifting teeth**

If you could change your smile would you:

- ☐ **Whiten your teeth**
- ☐ **Straighten your teeth**
- ☐ **Close Spaces**
- ☐ **Replace silver-metal fillings with tooth colored fillings**
- ☐ **Repair chipped teeth**
- ☐ **Replace missing teeth**
- ☐ **Replace old crowns that don't match**
- ☐ **Have a smile makeover**

Do you have or have you had any of the following:

- ☐ **Full or partial dentures**
- ☐ **Braces**
- ☐ **Periodontal gum treatments**

Do you smoke or chew tobacco? ☐ **Yes** ☐ **No**
How much?_____ For how long?_____
Is keeping your teeth important to you? ☐ **Yes** ☐ **No**
Why did you leave your last dentist? _____
On a scale of 1 – 10, with 10 the highest rating:
How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10
What is the most important thing to you about your future smile and dental health? _____
What is the most important thing to you about your dental visit today?_____

HEALTH INFORMATION

- ☐ AIDS / HIV Positive
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Artificial Heart Valve
- ☐ Bruise Easily
- ☐ Blood Disease
- ☐ Cancer
- ☐ Circulatory Problems
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Digestive Problems
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Fainting /Dizziness/ or Blackouts
- ☐ Epilepsy or Seizure
- ☐ Facial/Head Injuries
- ☐ Glaucoma/ Eye Problems
- ☐ Hay fever
- ☐ Excessive Bleeding
- ☐ Heart Pacemaker
- ☐ Heart Murmur
- ☐ Heart Disease or Attack
- ☐ Hepatitis A / B / C
- ☐ Kidney Trouble
- ☐ Liver Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Nervous / Mental Disorders
- ☐ Nerve Disorder
- ☐ Orthopedic Pins
- ☐ Psychiatric Treatment
- ☐ Pregnant Now Due Date:_____
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Tumors

ALLERGIES:

- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Other:_____
- ☐ PREMED Yes / No

SIGNATURE OF RESPONSIBLE PARTY:_____ ***DATE:***_____

DOCTOR SIGNATURE: _____ ***DATE:***_____

SIGNATURE OF RESPONSIBLE PARTY: _____ ***DATE:*** _____

DOCTOR SIGNATURE: _____ ***DATE:*** _____