CONFIDENTIAL PATIENT INFORMATION-PLEASE PRINT

DATE _____

NAME _____ (FIRST / MI / LAST) BIRTHDATE _____ SOC. SEC.# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

❑ MALE ❑ FEMALE ❑ MINOR MARITIAL STATUS _____ DRIVER'S LIC.# _____ HOME PHONE# _____

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE# _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

PARENT'S OR SPOUSE'S NAME _____ EMPLOYER _____ WORK PHONE# _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE _____ CITY _____ STATE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____ PHONE# _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE# _____ WORK PHONE# _____

DRIVER'S LICENSE# _____ BIRTHDATE _____ EMPLOYER _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ❑ YES ❑ NO

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE COVERAGE:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY# _____ INS. EFFECTIVE DATE _____

NAME OF EMPLOYER _____ WORK PHONE# _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP# _____ UNION OR LOCAL# _____

INS. COMPANY ADDRESS _____ CITY _____ STATE _____ ZIP _____

WHAT IS YOUR DEDUCTIBLE? _____ MAXIMUM ANNUAL BENEFIT? _____ HOW MUCH USED? _____

IF YOU HAVE ADDITIONAL DENTAL INSURANCE COMPLETE THE FOLLOWING:

SECONDARY INSURANCE COVERAGE:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY# _____ INS. EFFECTIVE DATE _____

NAME OF EMPLOYER _____ WORK PHONE# _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP# _____ UNION OR LOCAL# _____

INS. COMPANY ADDRESS _____ CITY _____ STATE _____ ZIP _____

WHAT IS YOUR DEDUCTIBLE? _____ MAXIMUM ANNUAL BENEFIT? _____ HOW MUCH USED? _____

I AUTHORIZE PAYMENT OF DENTAL BENEFITS TO THE DENTIST

X _____ DATE _____

PATIENT MEDICAL HISTORY

PATIENT NAME

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
ARE YOU UNDER MEDICAL TREATMENT NOW?	❑	❑
HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGERY OR SERIOUS ILLNESS?	❑	❑
ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	❑	❑
DO YOU USE TOBACCO?	❑	❑
DO YOU USE ALCOHOL?	❑	❑
DO YOU USE COCAINE OR OTHER DRUGS?	❑	❑

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING:

	YES	NO
DENTAL ANESTHETICS (NOVOCAINE)	❑	❑
PENICILLIN OR OTHER ANTIBIOTICS	❑	❑
SULFA DRUGS	❑	❑
ASPIRIN	❑	❑
SEDATIVES	❑	❑
IODINE	❑	❑
LATEX	❑	❑
CODEINE	❑	❑

OTHER ALLERGIES — WHAT ARE THEY? _____

LIST MEDICATIONS: _____

_____

WOMEN ONLY NEED ANSWER:

	YES	NO
ARE YOU (OR THINK YOU MAY BE) PREGNANT?	❑	❑
ARE YOU NURSING?	❑	❑
ARE YOU TAKING BIRTH CONTROL PILLS?	❑	❑

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

YES	NO		YES	NO		YES	NO	
❑	❑	HIGH BLOOD PRESSURE	❑	❑	SINUS PROBLEMS	❑	❑	TUBERCULOSIS/TB
❑	❑	LOW BLOOD PRESSURE	❑	❑	KIDNEY DISEASE	❑	❑	STOMACH ULCERS/TROUBLE
❑	❑	HEART DISEASE/TROUBLE	❑	❑	THYROID DISORDER	❑	❑	HEPATITIS/JAUNDICE
❑	❑	CHEST PAINS OR ANGINA	❑	❑	LIVER DISEASE	❑	❑	SEXUALLY TRANSMITTED DIS.
❑	❑	HEART ATTACK	❑	❑	BACK PAIN	❑	❑	AIDS OR HIV INFECTION
❑	❑	CARDIAC PACEMAKER	❑	❑	FREQUENTLY TIRED	❑	❑	GLAUCOMA
❑	❑	CONGENITAL HEART DEFECT	❑	❑	LEUKEMIA/ANEMIA	❑	❑	ARTHRITIS
❑	❑	MITRAL VALVE PROLAPSE	❑	❑	RADIATION THERAPY	❑	❑	ASTHMA
❑	❑	HEART VALVE REPLACEMENT	❑	❑	SWOLLEN ANKLES	❑	❑	EMPHYSEMA
❑	❑	RHEUMATIC FEVER	❑	❑	FAINTING/SEIZURES	❑	❑	HAY FEVER/ALLERGIES
❑	❑	JOINT REPLACEMENT/IMPLANT	❑	❑	STROKE	❑	❑	JAW PROBLEMS TMJ/TMD
❑	❑	DIABETES	❑	❑	EPILEPSY/CONVULSIONS	❑	❑	OTHER: _____
❑	❑	HEADACHES/FREQUENT	❑	❑	SHINGLES			_____

PATIENT DENTAL HISTORY

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	❑	❑
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/ FOODS?	❑	❑
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/ FOODS?	❑	❑
DO YOU FEEL PAIN IN ANY OF YOUR TEETH?	❑	❑
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	❑	❑
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	❑	❑
CLICKING?	❑	❑
PAIN (JOINT, EAR, SIDE OF FACE)?	❑	❑
DIFFICULTY IN OPENING OR CLOSING?	❑	❑

	YES	NO
HAVE YOU EVER HAD INSTRUCTION IN THE CORRECT METHOD OF BRUSHING YOUR TEETH?	❑	❑
HAVE YOU EVER HAD INSTRUCTIONS IN THE CARE OF YOUR GUMS?	❑	❑
HAVE YOU EVER HAD DIFFICULT EXTRACTIONS IN THE PAST?	❑	❑
HAVE YOU EVER HAD ANY ORTHODONTIC WORK?	❑	❑
HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	❑	❑
DIFFICULTY IN CHEWING?	❑	❑
DO YOU HAVE FREQUENT HEADACHES?	❑	❑
DO YOU CLENCH OR GRIND YOUR TEETH?	❑	❑

COMMENTS: _____

_____

_____

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X _____ _____

PATIENT, PARENT OR GUARDIAN DATE