Thank you for selecting our dental healthcare team! We strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us we will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL)

DATE ________________________________

NAME ____ BIRTHDATE ________________________

ADDRESS ____CITY/STATE ______________________________

ZIP ________________________ HOME PHONE ___________________________ CELL PHONE ________________________

EMAIL ADDRESS ____SS # ______________________________

IF STUDENT, NAME OF SCHOOL/COLLEGE ________________________________CITY/STATE________________________________

MINOR SINGLE MARRIED DIVORCED WIDOWED SEPERATED (circle one) MALE FEMALE (circle one)

PATIENT'S OR PARENT'S EMPLOYER____WORK PHONE: ________________________

BUSINESS ADDRESS____CITY_____________________STATE/ZIP___________________

SPOUSE OR PARENT'S NAME______________________________EMPLOYER________________________WORK PHONE______________________

EMERGENCY CONTACT____PHONE________________________________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR CLINIC____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT__________________________________ RELATIONSHIP______________________

ADDRESS ____CITY__________________STATE______________ZIP_____________

HOME PHONE_______________________________CELL PHONE_________________________WORK PHONE ________________________

EMPLOYER_______________________________________SS#_________________________________

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION:

NAME OF INSURED____RELATIONSHIP TO PATIENT_______________________

BIRTHDATE___________________SS#_______________________EMPLOYER_____________________________________

DENTAL INSURANCE COMPANY_______________________________________GROUP #__________________ID#_____________________

INSURANCE COMPANY ADDRESS____

CITY___________________________STATE_______________ZIP__________________PHONE_______________________________

SECONDARY INSURANCE INFORMATION:

NAME OF INSURED____RELATIONSHIP TO PATIENT_______________________

BIRTHDATE___________________SS#_______________________EMPLOYER_____________________________________

DENTAL INSURANCE COMPANY_______________________________________GROUP #__________________ID#_____________________

INSURANCE COMPANY ADDRESS____

CITY___________________________STATE_______________ZIP__________________PHONE_______________________________

PATIENT MEDICAL HISTORY

PHYSICIAN_______________________________OFFICE PHONE____________________DATE OF LAST PHYSICAL___________________

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

High Blood Pressure	YES NO	Heart Disease	YES NO	Heart Murmur	YES NO
Heart Attack	YES NO	Cardiac Pacemaker	YES NO	Mitral Valve Prolapse	YES NO
Rheumatic Fever	YES NO	Stroke	YES NO	Angina	YES NO
Allergies	YES NO	Fainting/Seizures	YES NO	Tuberculosis	YES NO
Frequently Tired	YES NO	Asthma	YES NO	Anemia	YES NO
Radiation Therapy	YES NO	Low Blood Pressure	YES NO	Emphysema	YES NO
Glaucoma	YES NO	Epilepsy/Convulsions	YES NO	Cancer	YES NO
Recent weight loss	YES NO	Leukemia	YES NO	Arthritis	YES NO
Liver Disease	YES NO	Diabetes	YES NO	Joint Replacement/Implant	YES NO
Kidney Diseases	YES NO	Hepatitis/Jaundice	YES NO	Respiratory Problems	YES NO
Aids or HIV infection	YES NO	Thyroid Problems	YES NO	Stomach Issues/Ulcers	YES NO
Chemical dependency	YES NO	Sinus Problems	YES NO	Psychiatric Care	YES NO
Neurologic/Parkinsons	YES NO	Autism/Aspergers	YES NO	Chemotherapy	YES NO

Other:____

Are you under medical treatment now? YES NO If YES, what for?____

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? YES NO If YES, please explain____

Are you taking any medications? YES NO If YES, please list or attach a list of medications currently taking:____

Do you smoke or use tobacco products?____

If Female: Are you taking hormones or use birth control? ____
Are you pregnant or nursing? ____

If you answered yes to allergies, please list:____

DO YOU TAKE A PRE-MED? YES NO

DENTAL HISTORY

DATE OF LAST DENTAL EXAM:_________________________HOW OFTEN DID YOU SEE YOUR DENTIST?___________________

Are your teeth sensitive to hot or cold liquids/food?	**YES**	**NO**
Have you ever had any dificult extractions in the past?	**YES**	**NO**
Have you had any orthodontic treatment?	**YES**	**NO**
Have you ever experienced any of the follow ing problems?		
Clicking?	**YES**	**NO**
Pain (joint, ear, sid of face)?	**YES**	**NO**
Difficulty in opening or closing?	**YES**	**NO**
Do you clench or grind your teeth?	**YES**	**NO**
Do you bite your lips or cheeks frequently?	**YES**	**NO**
Do you have any sores or lumps in or near your mouth?	**YES**	**NO**
Have you ever had any prolonged bleeding after an extraction?	**YES**	**NO**
Do you like your smile?	**YES**	**NO**
Do you w ear dentures or partials?	**YES**	**NO**
If yes, date of placement?______________________		
Have you ever had hygiene instructions?	**YES**	**NO**

Signature____**Date**__________________________