Patient Information Confidential

(Please print clearly) Date_____

Name_____ Preferred name_____ Birth date_____

Home Phone_____ Cell Phone_____ Work Phone_____ Please circle the best contact# to use.

Address_____State_____Zip_____

Social Security Number_____-____-_____ Gender_____Male _____Female

Email address_____

Check appropriate line_____Minor_____Single_____Married_____Divorced_____Widowed_____Separated

Employer_____Work phone_____ext____Address_____

If patient is a student, name and address of school_____

Whom may we thank for referring you to our office?_____

Person to contact in case of an emergency_____Phone_____

If Patient is a Minor

Name of person responsible for this account_____Realtionship_____

(Who is responsible for the bill)

Address_____Home phone_____Cell Phone_____

Birth date_____SS#____-____-_____Employer_____

Work phone_____ext_____

Is this person currently a patient in our office?____Yes____No

Insurance Information

In order for your services to be submitted to your insurance company, this section must be completely and accurately filled out.

Name of Insured_____Relationship to patient_____

Birth date_____SS#/Insurance ID#_____

Name of Employer_____Work phone_____

Address of Employer_____State_____Zip_____

Insurance Company_____Group #_____

Do you have any additional dental insurance?_____Yes_____No If yes, please complete the following

Name of Insured_____Relationship to patient_____

Birth date_____SS#/Insurance ID#_____

Name of Employer_____Work phone_____

Address of Employer_____State_____Zip_____

Insurance Company_____Group #_____

-

Signature_____**Date**_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered.

Medical History

Who is your current physician?_____

What is the phone number?_____

Have you ever been hospitalized for any surgical operation or serious illness? If yes, please explain._____

Are you taking any medication(s) including non-prescription (over-the-counter) meds?_____

If yes, what meds are you taking?_____

Do you use tobacco products?_____

Do you use alcohol or other drugs?_____

Are you wearing contact lenses?_____

Are you required to have an antibiotic premedication before dental and/or surgical procedures?? o yes o no

WOMEN ONLY:

Are you pregnant or think you may be?_____

Are you nursing?_____

Are you taking birth control pills?_____

Dental History

What is the reason for your visit today (chief concern)?_____

Who is your previous dentist?_____

When was your last dental visit?_____

Do your gums bleed when brushing or flossing?_____

Are your teeth sensitive to cold/hot?_____

Are your teeth sensitive to sweet/sour foods?_____

Do you feel pain to any of your teeth?_____

Do you have any sores/lumps in or near your mouth?_____

Have you had any head, neck or jaw injuries?

Please, explain._____

Have you ever experienced any of the following problems in your jaw?

oClicking

oPain (joint, ear, side of face)

oDifficulty opening closing

oDifficulty chewing

Do you have frequent headaches?_____

Do you clench or grind your teeth?_____

Do you bite your lips or cheeks frequently?_____

Have you had any extractions (teeth removed)?_____

Have you had braces (orthodontic work)?_____

Have you ever had prolonged bleeding following extractions?_____

Are you allergic to/have had any reactions to the following: (please check all that apply)

o Penicillin or other antibiotics?
o Sulfa drugs?
o Local anesthetic (novacaine)?
o Barbiturates?
o Sedatives?
o Aspirin?
o Ibuprofen?
o Iodine?
o Food/ preservative allergies?
o Other, please specify?

o None of these

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

o High blood pressure
o Heart attack
o Heart disease
o Chest pains
oCardiac pacemaker
oEasily winded
o Rheumatic fever
o Heart murmur
o Thyroid problem
o Stomach trouble/ulcer
o Stroke
o Swollen ankles
o Angina
o Hay fever/ allergies
o Fainting/seizures
o Frequently tired
oTuberculosis
o Asthma
o Anemia
o Radiation Therapy
o Low Blood Pressure
o Emphysema
o Glaucoma
o Epilepsy/convulsions
o Cancer
o Recent weight loss
o Leukemia
o Arthritis
o Liver disease
o Diabetes
o Joint replacement/implant
o Heart trouble
o Kidney diseases
o Hepatitis/jaundice
o Heart trouble
o AIDS/HIV
o Sexually Transmitted Dzs
o Respiratory problems
o Other (anything not listed):_____

_____

o None of these

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 dangerous to my health.

Signature:_____

Date:_____