Patient Information:

Last Name: _____ First Name: _____
Middle Initial: _____ Nickname: _____
Street: _____
Street 2: _____
City: _____ State: _____ Zip: _____
Phone: (_____) _____-_____
Work: (_____) _____-_____
Mobile: (_____) _____-_____
E-mail: _____
Student Status: Non-Student Part Time Full Time
Gender: Female Male Other
Marital Status: Married Single Child Other: _____
Birthdate: _____
SSN: _____-_____- _____

Head of Household Information

Head of Household Name: _____
Relation to Patient: _____

Primary Insurance Information

Subscriber is: _____
Employer: _____
Insurance Name: _____
Subscriber ID: _____
Plan/Group Number: _____

Secondary Insurance Information

Subscriber is: _____
Employer: _____
Insurance Name: _____
Subscriber ID: _____
Plan/Group Number: _____

Health History

Previous Dentist:

Name: _____

Address: _____

Phone: (_____) _____-_____

May we request your records? Yes No

Have you had a full mouth survey of X-rays in 3 years? Yes No

Physician:

Name: _____

Phone: (_____) _____-_____

Dental History:

What is your chief dental concern at this time? _____

How long has it been since your last dental visit? _____

Are your teeth sensitive to hot, cold, sweets or pressure? Yes No

Are you happy with your smile (Tooth size, shape, position, color)? Yes No

Have you ever had Orthodontic Treatment (Braces)? Yes No

Have you ever had any injuries to your teeth or jaw joints? Yes No

Do your gums bleed easily? Yes No

Do you floss? Yes No

Does food wedge between your teach causing discomfort? Yes No

Do you have any fears about Dental treatment? Yes No

Would you consider yourself dent phobic? Yes No

Would you like to be sedated for your appointment? Yes No

If yes: N20-Laughing gas or Valium (circle one)

Have you had any unusual experiences resulting from Dental care? Yes No

---

Medical History:

Date of last physical exam? _____

Are you currently under a Physicians care? Yes No

Have you ever had a serious illness, operation, or been hospitalized? Yes No

Have you ever been treated for psychiatric illness, or seen a Psychologist for any reason? Yes No

Do you have any allergies to any medications o materials? Yes No

If yes, please list: _____

Do you smoke or use tobacco products? Yes No

If yes, how many packs a day? _____

For how many years? _____

Have you ever, during your lifetime, used these products? Yes No

If yes, how long? _____

Do you have any allergies to any medication or materials? Yes No

If yes, please list: _____

Do you have a Heart Murmur or Artificial Prosthesis which requires that you receive antibiotics prior to Dental Treatment? Yes No

---

Women:

Are you taking Birth Control Pills? Yes No

Are you currently pregnant or is there a chance you may be? Yes No

Are you nursing? Yes No

Are you taking any hormone supplements? Yes No

Medical Conditions and Alerts:

(Please circle Yes or No)

Anemia: Yes No

Arthritis, Rheumatism: Yes No

Artificial Heart Valves: Yes No

Asthma: Yes No

Back Problems: Yes No

Bleeding Abnormally: Yes No

Blood Disease: Yes No
Cancer: Yes No
Chemical Dependency: Yes No
Chemotherapy: Yes No
Circulatory Problems: Yes No
Congenital Heart Lesions: Yes No
Cortisone Treatments: Yes No
Cough, Persistent: Yes No
Cough up Blood: Yes No
Diabetes: Yes No
Epilepsy: Yes No
Fainting: Yes No
Glaucoma: Yes No
Headaches: Yes No
Heart Murmur: Yes No
Heart Problems: Yes No
Hemophilia: Yes No
Hepatitis: Yes No
Hernia Repair: Yes No
High Blood Pressure: Yes No
HIV/AIDS: Yes No
Jaw Pain: Yes No
Kidney Disease: Yes No
Liver Disease: Yes No
Mitral Valve Prolapse: Yes No
Pacemaker: Yes No
Radiation Treatment: Yes No
Respiratory Disease: Yes No
Rheumatic Fever: Yes No
Scarlet Fever: Yes No
Shortness of Breath: Yes No
Skin Rash: Yes No
Stroke: Yes No
Swelling of Feet or Ankles: Yes No
Thyroid Problems: Yes No
Tobacco Habit: Yes No
Tonsillitis: Yes No
Tuberculosis: Yes No
Ulcer: Yes No

Venereal Disease: Yes No

Allergy - Aspirin: Yes No
Allergy - Barbiturates: Yes No
Allergy - Codeine: Yes No
Allergy - Local Anestheic: Yes No
Allergy - Penicillin: Yes No
Allergy - Sulfa: Yes No
Allergy - Iodine: Yes No
Allergy - Latex: Yes No

Premedicate: Yes No