Patient Information

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

PATIENT INFORMATION

Name: _____ Preferred Name: _____

Address: _____
Street City State Zip

Birthdate: ____/____/_____ Age___ SS# ____ -____-____ Marital Status _____

Email: _____ Home # _____

Work #_____ Mobile #_____

Whom may we thank for referring you? _____

Employer _____ Employer Ph # _____

Employer Address_____

Spouse Info

Name: _____ Birthdate: ____/____/____
Home #_____ Work # _____
Mobile #_____ Email: _____

ACCOUNT INFO

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

SS # _____ Birthdate: _____

Home# _____ Work # _____

Billing Address _____

INSURANCE

Subscriber's Name: _____ Relation: _____

Subscriber's Birthdate: ____/____/____ Subscriber's Ph # _____

Subscriber's SS# _____ Subscriber's Employer _____

CONTACT INFO

IN THE EVENT OF AN EMERGENCY,
WHO SHOULD WE CONTACT?

Name: _____ Relation: _____
Home # _____ Work #_____

MEDICAL HISTORY

Y	N	Conditions	Y	N	Conditions	Y	N	Conditions
☐	☐	Abnormal Bleeding	☐	☐	Glaucoma	☐	☐	Stroke
☐	☐	Alcohol Abuse	☐	☐	HIV+ AIDS	☐	☐	Thyroid Problems
☐	☐	Allergies	☐	☐	Hay Fever	☐	☐	Tuberculosis
☐	☐	Anemia	☐	☐	Heart Attack	☐	☐	Ulcers
☐	☐	Angina Pectoris	☐	☐	Heart Surgery	☐	☐	Venereal Disease
☐	☐	Arthritis	☐	☐	Hemophilia	☐	☐	Yellow Jaundice
☐	☐	Artificial Heart Valve	☐	☐	Hepatitis A			
☐	☐	Artificial Joints	☐	☐	Hepatitis B			
☐	☐	Asthma	☐	☐	High Blood Pressure			**ALLERGIES**
☐	☐	Blood Transfusion	☐	☐	Kidney Problems	Y	N	
☐	☐	Cancer- Chemotherapy	☐	☐	Liver Disease	☐	☐	Aspirin
☐	☐	Colitis	☐	☐	Low Blood Pressure	☐	☐	Codeine
☐	☐	Congenital Heart Defect	☐	☐	Mitral Valve Prolapse	☐	☐	Dental Anesthetics
☐	☐	Cosmetic Surgery	☐	☐	Pace Maker	☐	☐	Erythromycin
☐	☐	Diabetes	☐	☐	Pneumocystitis	☐	☐	Jewelry
☐	☐	Difficulty Breathing	☐	☐	Psychiatric Problems	☐	☐	Latex
☐	☐	Drug Abuse	☐	☐	Radiation Therapy	☐	☐	Metals
☐	☐	Emphysema	☐	☐	Rheumatic Fever	☐	☐	Penicillin
☐	☐	Epilepsy	☐	☐	Seizures	☐	☐	Tetracycline
☐	☐	Fainting Spells	☐	☐	Shingles	**Other** _____		
☐	☐	Fever Blisters	☐	☐	Sickle Cell Disease	_____		
☐	☐	Frequent Headaches	☐	☐	Sinus Problems	_____		

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ____
☐	☐	Are you nursing?

Y	N	
☐	☐	Do you smoke or use Tobacco?

Height:_____ Weight: _____

DENTAL HISTORY

Why have you come to the dentist today?
_____
_____
_____
_____
_____

Approximate date of:
Your last cleaning _____
Your last x-rays _____

Who was your previous dentist?

Name:_____ Phone: _____

Has your doctor told you that you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss? _____
How many times a day do you brush? _____
Type of toothbrush bristles? ☐ Hard ☐ Medium ☐ Soft

MEDICATIONS

☐ **Yes** ☐ **No** Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below….

Notes:

Signature: _____ Date: _____
(If under 18, Parent or Guardian Signature Required)