

PATIENT INFORMATION

CONFIDENTIAL

(PLEASE PRINT) SOCIAL SECURITY # _____

NAME _____ BIRTHDATE _____ TODAY'S DATE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL _____ HOME PHONE _____ CELL PHONE _____

CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

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

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

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

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY # _____ BIRTHDATE _____ HOME PHONE _____

EMPLOYER _____ WORK PHONE _____

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

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY # _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY # _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

MY DENTAL INFORMATION MAY BE SHARED WITH THE FOLLOWING PEOPLE: _____

X _____ **SIGNATURE**

SIGNATURE OF PATIENT OR PARENT IF MINOR

CONFIDENTIAL PATIENT INFORMATION

PATIENT MEDICAL HISTORY

PATIENT NAME _____

TODAY'S DATE _____

PHYSICIAN _____

OFFICE PHONE _____

DATE OF LAST EXAM _____

ARE YOU UNDER MEDICAL TREATMENT NOW?	Y	N	DO YOU, OR HAVE YOU TAKEN PHEN-FEN, REDUX, OR ORAL BISPHOSPHONATES?	Y	N
HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	Y	N	ARE YOU CURRENTLY TAKING ANY BLOOD THINNERS? _____	Y	N
DO YOU USE TOBACCO? _____	Y	N	DO YOUR GUMS BLEED EASILY?	Y	N
DO YOU, OR HAVE YOU USED CONTROLLED SUBSTANCES? IF YES, EXPLAIN _____	Y	N	DO YOU SUFFER FROM COLD SORES/CANKER SORES?	Y	N
			ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? _____	Y	N

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

PENICILLIN SULFA DRUGS BARBITUATES LOCAL ANESTHETICS NONE
 IODINE LATEX SEDATIVES ASPIRIN OTHER _____

WOMEN ONLY

ARE YOU PREGNANT OR TRYING TO GET PREGNANT? Y N
 ARE YOU NURSING? Y N
 ARE YOU TAKING ORAL CONTRACEPTIVES? Y N

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING?

Y N HIGH BLOOD PRESSURE	Y N DIABETES	Y N ARTHRITIS
Y N LOW BLOOD PRESSURE	Y N GLAUCOMA	Y N HEPATITIS / JAUNDICE
Y N HEART ATTACK	Y N CANCER	Y N SEXUALLY TRANSMITTED DISEASE
Y N HEART MURMUR	Y N LEUKEMIA	Y N AIDS OR HIV INFECTION
Y N HEART DISEASE	Y N RADIATION THERAPY	Y N ANEMIA
Y N CARDIAC PACEMAKER	Y N CHEMOTHERAPY (PORT Y/N)	Y N ALZHEIMER'S/ DEMENTIA
Y N ANGINA	Y N DIALYSIS (PORT Y/N)	Y N LIVER DISEASE
Y N ARTIFICIAL HEART VALVE / STENT	Y N KIDNEY DISEASE	Y N HAY FEVER / ALLERGIES
Y N CONGESTIVE HEART FAILURE	Y N ASTHMA	Y N TUBERCULOSIS
Y N MITRAL VALVE PROLAPSE	Y N EMPHYSEMA	Y N RECENT WEIGHT LOSS
Y N ARRHYTHMIA	Y N RESPIRATORY PROBLEMS	Y N PSYCHIATRIC CARE
Y N STROKE	Y N EPILEPSY / CONVULSIONS	Y N STOMACH TROUBLES / ULCERS
Y N RHEUMATIC FEVER	Y N THYROID PROBLEM	OTHER: _____
Y N JOINT REPLACEMENT OR IMPLANT -TYPE _____		

MEDICATIONS

SIGNATURE OF DENTIST: _____

DATE: _____

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 _____ DATE _____
 PATIENT, PARENT, OR GUARDIAN

X _____ DATE _____
 PATIENT, PARENT, OR GUARDIAN

X _____ DATE _____
 PATIENT, PARENT, OR GUARDIAN

X _____ DATE _____
 PATIENT, PARENT, OR GUARDIAN