

## PATIENT INFORMATION

PATIENT'S NAME Last First Middle Initial SEX: M F Birthdate Age  
 Soc. Sec. # If Patient is a Minor, give Parent's or Guardian's Name Today's Date  
 Who May We Thank for referring You to our Office? Reason for this Visit

## RESPONSIBLE PARTY INFORMATION

NAME Last First Middle Initial MARITAL STATUS  
 RESIDENCE Street Apt. # City State ZIP  
 MAILING ADDRESS Street Apt. # City State ZIP  
 HOW LONG AT THIS ADDRESS HOME PHONE CELL PHONE  
 WORK PHONE EMAIL  
 PREVIOUS ADDRESS (if less than 3 yrs) Street City State Zip How long  
 SOCIAL SECURITY # BIRTHDATE DRIVER'S LICENSE # RELATION TO PATIENT  
 EMPLOYER OCCUPATION NO. YEARS EMPLOYED

### RESPONSIBLE PARTY SPOUSE

NAME LAST FIRST MIDDLE ( )  
 EMPLOYER OCCUPATION NO. YEARS EMPLOYED  
 SOC. SEC # BIRTHDATE  
 HOME PH. CELL PH.  
 WORK PH. EMAIL

### EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME  
 EMPLOYER OCCUPATION ( )  
 HOME PH. CELL PH.  
 WORK PH. EMAIL

### DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name  
 Insurance Co. E-Mail  
 Insurance Co. Address  
 Insured's Employer  
 Insured's Soc. Sec. # Group # Local #

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name  
 Insurance Co. E-Mail  
 Insurance Co. Address  
 Insured's Employer  
 Insured's Soc. Sec. # Group # Local #

*It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.*

### \*DENTAL HISTORY\*

YES NO

### \*MEDICAL HISTORY\*

YES NO

HOW LONG SINCE you have seen a dentist?  
 Last COMPLETE Dental Exam, Date:  
 Last FULL MOUTH X-RAYS, DATE: (16 small Films or Panoramic)  
 Are you having PROBLEMS now?

WHAT?  
 Is your present dental health POOR?  
 Do you wear DENTURES? (Partials or Full)  
 Are you UNHAPPY with your dentures?

Would you like to know more about PERMANENT REPLACEMENTS?  
 Are you APPREHENSIVE about dental treatment?  
 Have you had any PERIODONTAL (GUM) treatments?  
 Do your gums BLEED, or feel TENDER or IRRITATED?  
 Are your teeth SENSITIVE to hot, cold, sweets, pressure?  
 Are you UNHAPPY with the APPEARANCE of your teeth?  
 Are you aware of GRINDING or CLENCHING your teeth?  
 Do you have HEADACHES, EARACHES, or NECK PAINS?  
 Have you worn BRACES on your teeth (ORTHODONTICS)  
 Do you have DISCOLORED teeth that bother you?  
 Would you like your smile to LOOK BETTER or DIFFERENT?  
 Do you REGULARLY use DENTAL FLOSS?

Name of Previous Dentist:  
 City: State:  
 How do you feel about your teeth?

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.

FEAR of pain # Lack of concern #

COST of treatment # MISSING work time #

Do you have any CURRENT HEALTH PROBLEMS?  
 Are you under a PHYSICIAN'S CARE now?  
 For what?  
 What MEDICATIONS are you currently taking?

Have you ever taken Fen-Phen/Redux?  
 Are you PREGNANT?  
 Do you use cigars/cigarettes, pipe or chewing tobacco?

PLEASE CHECK YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

YES NO		YES NO		YES NO	
AIDS/HIV Pos.		Fainting		Psychiatric care	
Anaphylaxis		Food allergies		Rapid weight gain/loss	
Anemia		Glaucoma		Radiation treatment	
Arthritis		Headaches		Respiratory disease	
Artificial heart valves		Heart murmur		Rheumatic scarlet fever	
Artificial joints		Heart problems (please describe)		Shingles	
Asthma				Shortness of breath	
Atopic (allergy prone)		Hemophilia (abdominal bleeding)		Skin rash	
Back problems		Herpes		Spina Bifida	
Blood disease		Hepatitis		Stroke	
Cancer		High blood pressure		Surgical implant	
Chemical dependency		Jaw pain		Swelling of feet or ankles	
Chemotherapy		Kidney disease or malfunction		Thyroid disease or malfunction	
Circulatory problems		Liver disease		Tobacco habit	
Cortisone treatments		Material allergies		Tonsilitis	
Cough (persistent)		(baker, mid, metal, chemicals)		Tuberculosis	
Cough up blood		Mitral valve prolapse		Ulcer Colitis	
Diabetes		Nervous problems		Venereal disease	
Epilepsy		Pacemaker, heart surgery			

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?  
 Aspirin Local Anesthetic Erythromyiein Latex (balloons, gloves, etc.)  
 Nitrous Oxide Codeine Penicillin

Are you aware of being allergic to any other medications or substances?  
 If yes, please list:

Is there any other Medical or Dental information that you feel I should know about?  
 FAMILY PHYSICIAN PHONE E-MAIL

PATIENT Signature (Parent of Child)

Date:

Dentist Signature: