**Date _____**

# Confidential Patient Information

ABC

Patient's Name _____ Marital Status _____
Last First Middle

Address _____
Street City State Zip

Telephone # Home: _____Work: _____Cell:_____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

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

# Confidential Responsible Party Information

Name_____ Marital Status _____
Last First Middle

Residence _____
Street City State Zip

How long at this address _____ Home Phone _____Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____Driver's License # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____No. Years Employed _____

**Spouse's** Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____Work Phone _____

# Insurance Information

Policy Holder's name _____ Social Security # _____Date of Birth _____

Insurance Company _____Group No. _____Policy #_____

Insurance Co. Address _____Insurance Co. Phone_____

Policy Holder's Employer _____

Do you have dual coverage? No Yes If yes:

Policy Holder's name _____ Social Security # _____Date of Birth _____

Insurance Company _____Group No. _____Policy #_____

Insurance Co. Address _____Insurance Co. Phone_____

Policy Holder's Employer _____

# Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship: _____

I understand that where appropriate, credit bureau reports may be obtained. If I cancel/reschedule my appointment in less than 24 working hours, I will pay $25 for every 30 minutes of scheduled time.

Signature (parent's signature if minor) _____

Updates (date & initial) _____

CONFIDENTIAL (For record and pretreatment evaluation)

# Dental History

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

_____

Are you currently in pain? ❑ Yes ❑ No

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

Have you ever had gum treatment? ❑ Yes ❑ No

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

Do you like your smile? ❑ Yes ❑ No

How many times a week do you floss? _____

How many times a day do you brush? _____ How long do you use a tooth brush before replacing it? _____

Type of bristles? ❑ Hard ❑ Medium ❑ Soft

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? ❑ Yes ❑ No If yes, why? _____

_____

# Medical History

**Your current physical health is:** ❑ **Good** ❑ **Fair** ❑ **Poor**

Are you currently under the care of a physician? ❑ Yes ❑ No Please explain: _____

_____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No If yes, how much for how long? _____

Are you taking any prescription / over-the-counter drugs? ❑ Yes ❑ No

Please list each one _____

_____

**For Women:** Are you taking birth control pills? ❑ Yes ❑ No Are you pregnant? ❑ Yes ❑ No Week #: _____

Are you nursing? ❑ Yes ❑ No

# Have you ever had any of the following diseases or medical problems?

| | | |
|---|---|---|
| Anemia | ❑ Yes | ❑ No |
| High / Low Blood Pressure | ❑ Yes | ❑ No |
| Heart Attack / Stroke | ❑ Yes | ❑ No |
| Heart Surgery / Pacemaker | ❑ Yes | ❑ No |
| Heart Murmur | ❑ Yes | ❑ No |
| Congenital Heart Defect | ❑ Yes | ❑ No |
| Mitral Valve Prolapse (MVP) | ❑ Yes | ❑ No |
| Rheumatic / Scarlet Fever | ❑ Yes | ❑ No |
| Epilepsy / Seizures | ❑ Yes | ❑ No |
| Fainting Spells | ❑ Yes | ❑ No |
| Diabetes | ❑ Yes | ❑ No |
| Tuberculosis (TB) | ❑ Yes | ❑ No |
| Artificial Bones / Joint | ❑ Yes | ❑ No |
| Artificial Valves | ❑ Yes | ❑ No |
| Difficulty Breathing / Emphysema | ❑ Yes | ❑ No |
| Asthma | ❑ Yes | ❑ No |

| | | |
|---|---|---|
| Arthritis | ❑ Yes | ❑ No |
| Glaucoma | ❑ Yes | ❑ No |
| Hepatitis | ❑ Yes | ❑ No |
| Blood Transfusion | ❑ Yes | ❑ No |
| Hemophilia / Abnormal Bleeding | ❑ Yes | ❑ No |
| Cancer / Chemotherapy / Radiation Treatment | ❑ Yes | ❑ No |
| HIV + / AIDS | ❑ Yes | ❑ No |
| Kidney Problems | ❑ Yes | ❑ No |
| Fever Blisters / Herpes | ❑ Yes | ❑ No |
| Shingles | ❑ Yes | ❑ No |
| Venereal Disease | ❑ Yes | ❑ No |
| Drug / Alcohol Abuse | ❑ Yes | ❑ No |
| Ulcers / Colitis | ❑ Yes | ❑ No |
| Severe / Frequent headaches | ❑ Yes | ❑ No |
| Psychiatric Problems | ❑ Yes | ❑ No |
| Sinus Problems | ❑ Yes | ❑ No |
| Hospitalized for Any Reason | ❑ Yes | ❑ No |

# Are you allergic to any of the following?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Aspirin | ❑ Yes | ❑ No | Erythromycin | ❑ Yes | ❑ No | Latex | ❑ Yes | ❑ No |
| Codeine | ❑ Yes | ❑ No | Tetracycline | ❑ Yes | ❑ No | Any Metal / Plastic | ❑ Yes | ❑ No |
| Dental Anesthetics | ❑ Yes | ❑ No | Penicillin | ❑ Yes | ❑ No | Other | ❑ Yes | ❑ No |

Please list any other drugs that you are allergic to: _____

Please list any serious condition(s) that you ever had: