Patient Name ____
Last Name First Name Initial
Mailing Address ________________________ City___________________ State ______Zip___________
Sex: M F Birthdate ___-___-______ Single Married Widowed Separated Divorced
Patient home Number #_____-_____-______ Cell phone Number: ______-______-______
e-mail_________________________@__________________
Patient Employed By ___________________________________Occupation _______________________
Business Address ____
Spouse or Parent (if patient is minor)______________________ Social Security #____-____-______
Spouse or Parents Employed By___________________________Occupation_______________________
Business Address____

Primary Dental Insurance________________________________Group#__________________________
ID# of Insured __________________________ Name of Insured_________________________________
Social Security # of Insured____-____-_______ Birthdate of Insured___-___-______

Secondary Dental Insurance______________________________Group#__________________________
ID# of Insured __________________________ Name of Insured_________________________________
Social Security # of Insured____-____-_______ Birthdate of Insured___-___-______

In case of emergency, who should be notified?____
Phone____-____-_______

Whom may we thank for referring you?____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I accept responsibility for payment of all dental services. I understand that if financing is required, credit reports may be obtained. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. This information will be kept confidential.

Date ____-____-_______ Signature ____
(Patient/Parent if patient is minor)

Dental History

Correct answers to the following questions will allow your dentist to treat you on a more individual basis.

1. What is your reason for visiting us today? ____
2. Are you having any discomfort at this time? Yes No Explain__________________________
3. Does dental treatment make you nervous? No Slightly Moderately Extremely
4. Previous Dentist_____________________Last visit_______________ Treatment__________________
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, and clench mouth)? Yes No
6. Are you satisfied with your smile? Yes No____
7. How often do you brush? ___________________________ Brush is? Soft Medium Hard
8. Do you use: Mouthwash Fluoride Floss Toothpick Other__________
9. Do you have or have you ever had any of the following?

Bleeding, Sore gums	Yes	No	Loose teeth	Yes	No
Unpleasant taste/bad breathe	Yes	No	Sensitivity to hot	Yes	No
Burning tongue/lip	Yes	No	Sensitivity to cold	Yes	No
Frequent blister, lip/mouth	Yes	No	Sensitivity to Sweets	Yes	No
Swelling /lumps in mouth	Yes	No	Sensitive to Biting	Yes	No
Ortho Treatment	Yes	No	Food Impaction	Yes	No
Biting Cheek/lip	Yes	No	Clenching /Grinding	Yes	No
Clicking /Popping jaw	Yes	No	Shifting in Bite	Yes	No
Difficulty opening and closing jaw	Yes	No	Change in Bite	Yes	No

9. Have you ever had any serious trouble associated with previous dentistry? Yes No
10. What is most important to you about your dental health: ____
11. What are your concerns? ____

Medical History

○ Heart Murmur
○ Heart Valve Problems/replacement
○ Heart Surgery /Pacemaker
○ Rheumatic Fever
○ Congenital Heart Defect
○ Stroke/Heart Attack
○ Joint Replacement (hip, knee, etc.)
○ Blood Pressure-High/ Low
○ Cholesterol
○ Allergies to Medication: Please list
○ Allergies to Latex or Metal
○ Allergies: other
○ Cancer/Chemotherapy
○ Radiation Treatment
○ Epilepsy/Seizures/Fainting Spells
○ Severe/Frequent Headaches
○ Sinus Problems
○ Tobacco Use _______ Years
○ Diabetes
○ Asthma
○ Respiratory Disease/tuberculosis
○ Hepatitis, Jaundice or Liver Disease
○ Glaucoma/Eye Disease
○ Psychiatric Problems
○ Nervous Problems
○ Chemical Dependency
○ Ulcer/Colitis
○ Shingles
○ Fever Blisters
○ Anemia
○ HIV+Aids
○ Venereal Disease
○ Arthritis
○ Osteoporosis
○ Thyroid Disorder
○ Herbals or Vitamins
○ Over the Counter Medication

List all Hospitalizations (for illness or surgery)

____
____
____

Woman

Are you or do you suspect you are Pregnant? Yes No

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or ant member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date ____-____-_______ Signed____

(Patient/Parent if patient is a minor)