Please complete the following
confidential information

Patient Information

1

Name_____ Preferred Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Home Ph #_____ Cell #_____ Married____ Single____ Divorced____ Widowed____

Date of Birth_____ E-Mail Address_____

Social Security #_____ Occupation_____

Employer_____ Business Phone_____ Ext._____

Business Address_____

YOUR SPOUSE:

Name_____ Social Security #_____ Date of Birth_____

Employer_____ Business Phone_____ Ext._____

Business Address_____ Occupation_____

If patient is a minor, please fill out section 2. If not, proceed to section 3.

2

MOTHER'S NAME:_____

Social Security #_____ D.O.B._____ Occupation_____ Business Phone_____ Ext._____

Employer_____ Business Address_____

FATHER'S NAME:_____

Social Security #_____ D.O.B._____ Occupation_____ Business Phone_____ Ext._____

Employer_____ Business Address_____

3

DENTAL INSURANCE

Primary Carrier

Insurance Co._____ Employee_____ Group #_____

Secondary Carrier

Insurance Co._____ Employee_____ Group #_____

MEDICAL INSURANCE

Primary
Insurance Co._____ Employer_____ Group #_____

4

GETTING TO KNOW YOU

Is another member of your family, or relative a patient at our office?_____

Referred to us by_____

Person to contact for an emergency_____ Phone_____

Closest relative not living with you_____

General Dentist_____

DATE _____ DATE OF BIRTH _____ MALE/FEMALE

NAME _____ HEIGHT _____ WEIGHT _____

PHYSICIAN _____ PHYSICIAN'S PHONE # _____ LAST PHYSICAL _____

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD:

	YES	NO	?
HEPATITIS, JAUNDICE OR LIVER DISEASE			
EPILEPSY, CONVULSIONS OR FAINTING SPELLS			
RHEUMATIC FEVER			
HEART MURMUR OR MITRAL VALVE PROLAPSE			
HEART TROUBLE OR STROKE			
HIGH OR LOW BLOOD PRESSURE			
SHORTNESS OF BREATH ON MILD EXERTION			
CHEST PAIN ON MILD EXERTION			
TUBERCULOSIS			
KIDNEY DISEASE OR INFECTION			
DIABETES			
A. ANY BLOOD RELATIVES			
B. DO YOU URINATE FREQUENTLY			
C. ARE YOU OFTEN THIRSTY			
ARTHRITIS OR RHEUMATISM			
STOMACH OR DUODENAL ULCERS			
MEDICAL RADIATION TREATMENT			
ASTHMA, HAY FEVER OR ALLERGIES			
EMPHYSEMA			
THYROID OR PARATHYROID DISEASES			
DRUG REACTION TO _____			
AIDS/HIV			
SEXUALLY TRANSMITTED DISEASES			
HOSPITALIZATION FOR ILLNESS OR SURGERY			
HIVES OR SKIN RASH			

	YES	NO	?
A TUMOR OR ABNORMAL GROWTH			
ANEMIA OR BLOOD DISORDERS			
ABNORMAL BLEEDING PROBLEMS			
ANTICOAGULANTS (BLOOD THINNER)			
EMOTIONAL PROBLEMS OR TENSION			
PROSTATE TROUBLE			
ALCOHOLISM/SUBSTANCE ABUSE			
OSTEOPOROSIS OR MEDICINE FOR OSTEOPOROSIS			
ANY SERIOUS ILLNESS NOT LISTED _____			

ARE YOU:

TAKING ANY MEDICATION NOW OR WITHIN THE LAST YEAR			
ALLERGIC TO DENTAL ANESTHETIC			
SUBJECT TO FREQUENT HEADACHES			
A NERVOUS PERSON			
TAKING NERVE OR SLEEPING MEDICATION			
OFTEN UNHAPPY OR DEPRESSED			
TAKING ANTIDEPRESSION MEDICATION			
DO YOU BRUISE EASILY			
DO YOU WEAR CONTACT LENSES			
DO YOU USE SMOKELESS TOBACCO			

IF YOU SMOKE, HOW MUCH _____

IF FEMALE, ARE YOU NOW (PLEASE CHECK IF YES)

PREGNANT _____ TAKING ORAL CONTRACEPTIVE DRUG _____

PRESENTLY IN MENOPAUSE _____ POST MENOPAUSE _____

DO YOU HAVE PROBLEMS WITH YOUR MENSTRUAL CYCLE _____

PLEASE LIST THE NAMES OF ALL MEDICATIONS YOU ARE PRESENTLY TAKING: _____

DENTAL HISTORY

	YES	NO	?
1. Are you having discomfort at this time?			
2. Have you ever had teeth straightened?			
3. Have you ever had head or face injuries?			
4. Would you be upset if you lost your teeth?			
5. Have you had previous gum treatment?			

6. How often have you had your teeth cleaned in the last 3 years? _____

7. When was the last time you had your teeth cleaned? _____

8. Which of the following cleaning aids do you use daily:
   toothbrush, floss, toothpick, stimulator, water pik, electric toothbrush?

Patient Signature _____

OFFICE USE ONLY _____