



WELCOME TO OUR OFFICE

Date _____

Patient's Name _____

Name Patient Uses _____ Email _____

Address _____ City _____ Zip _____

Patient's Date of Birth _____ Present Age _____ Gender _____ Phone _____

Name of Referral Dentist _____ Whom may we thank for referring this office _____

If student, school _____ Hobbies/Sports _____

Names and Ages of Other Children in Family _____

Father's/Husband's Name _____ Mother's/Wife's Name _____

HEALTH HISTORY

Has there been any problem in your general health? *(Serious illness, hospitalization, surgery, regular physician visits and continuing medical care.)*

Date of last medical checkup _____ Physician _____

What tablets, pills, liquids do you take regularly? *(That includes fluoride, aspirin, vitamins, alcohol, etc.)*

Do you use tobacco? Y N If yes, for how long? _____ *(circle one or both if applicable)* Smoke Chew

Have you ever, or are you now taking biphosphonates? *(Such as Boniva, Fosamax or Actonel)* Y N If yes, for how long? _____

Do you have, or have you had any of the following diseases or problems?

	Yes	No		Yes	No		Yes	No
Stomach or digestive upset or distress ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells, seizures, blackouts, epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever, heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice, liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Tumors	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble, heart attach, stroke	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment for a tumor or other growth	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Venereal diseases	<input type="checkbox"/>	<input type="checkbox"/>	Sores that do not heal within one week	<input type="checkbox"/>	<input type="checkbox"/>
Pain in chest, shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	HIV (Human Immunodeficiency Virus)	<input type="checkbox"/>	<input type="checkbox"/>	Unusual weight gain or loss	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorders, anemia	<input type="checkbox"/>	<input type="checkbox"/>	AIDS (Acquired Immune Deficiency Syndrome)	<input type="checkbox"/>	<input type="checkbox"/>	Are you sensitive or allergic to medications/drugs	<input type="checkbox"/>	<input type="checkbox"/>
Blood test with unusual result	<input type="checkbox"/>	<input type="checkbox"/>	Kidney troubles	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what? _____	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding, prolonged healing, bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis, other lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic to any metals	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Severe persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic to any jewelry	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Women, Are you pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic to latex	<input type="checkbox"/>	<input type="checkbox"/>

DENTAL HISTORY

Purpose of visit and/or chief complaint _____

Are you aware of any particular dental problems? Y N If yes, please explain _____

Do you have any dental discomfort or pain in the face, neck or jaw? Y N If yes, please explain _____

Approximate month of your last visit to a dental office _____

How would you rate the appearance of your teeth? pleased satisfied displeased

Does patient vomit, gag or faint easily? Y N

Has the patient ever received a blow to the teeth or jaws? Y N If yes, please give brief description including date _____

Is there, or has there been, a thumb or finger sucking habit? Y N If yes, please explain _____

Has any member of the family had orthodontic treatment? Y N If yes, when? _____

Has patient had speech therapy? Y N Have a specific learning disability? Y N Behavior disorder? Y N

Has the patient ever had a popping, clicking, grinding or grating noise in the joints just in front of the ear (TMJ)? Y N



Date _____

CONFIDENTIAL PATIENT INFORMATION

Patient's Name _____

Address (Street, City, State, Zip) _____

Home Phone _____ Birthdate _____ Social Security # _____

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

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Name (Last, First, Middle) _____ Marital Status _____

Residence (Street, City, State, Zip) _____ Rent Own

Mailing Address (Street, City, State, Zip) _____

How long at this address _____ Phone (Home/Cell) _____ Work Phone _____

Previous Addresss (If less than 3 years) _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ Numbers of Years Employed _____

Spouse's (Last, First, Middle) _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ Numbers of Years Employed _____

INSURANCE INFORMATION

Policy Holder's Name _____ Birthdate _____ Social Security # _____

Policy Holder's Employer _____ Insurance ID# _____

Insurance Company _____ Group # _____ Union Local # _____

Insurance Co. Address _____ Insurance Co. Phone _____

Do you have dual coverage? Y N

IF YES

Policy Holder's Name _____ Birthdate _____ Social Security # _____

Policy Holder's Employer _____ Insurance ID # _____

Insurance Company _____ Group # _____ Union Local # _____

Insurance Co. Address _____ Insurance Co. Phone _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Address (Street, City, State, Zip) _____

Phone (Home/Cell) _____ Relationship _____

I understand that where appropriate, credit bureau reports may be obtained

Signature (Parent signature if minor) _____

Updates (date & initial) _____