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
Stomach or digestive upset or distress ulcers	☐	☐
Rheumatic fever, heart murmur	☐	☐
Heart trouble, heart attach, stroke	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐
Pain in chest, shortness of breath	☐	☐
Blood disorders, anemia	☐	☐
Blood test with unusual result	☐	☐
Abnormal bleeding, prolonged healing, bruise easily	☐	☐
Asthma	☐	☐
Hay Fever	☐	☐

	Yes	No
Fainting spells, seizures, blackouts, epilepsy	☐	☐
Jaundice, liver disease	☐	☐
Arthritis	☐	☐
Hepatitis	☐	☐
Venereal diseases	☐	☐
HIV (Human Immunodeficiency Virus)	☐	☐
AIDS (Acquired Immune Deficiency Syndrome)	☐	☐
Kidney troubles	☐	☐
Tuberculosis, other lung disease	☐	☐
Severe persistent cough	☐	☐
Women, Are you pregnant	☐	☐

	Yes	No
Diabetes	☐	☐
Tumors	☐	☐
Cancer	☐	☐
Radiation treatment for a tumor or other growth	☐	☐
Sores that do not heal within one week	☐	☐
Unusual weight gain or loss	☐	☐
Are you sensitive or allergic to medications/drugs	☐	☐
If yes, what? _____	☐	☐
Are you allergic to any metals	☐	☐
Are you allergic to any jewelry	☐	☐
Are you allergic to latex	☐	☐

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 ☐ unpleased ☐

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)* _____