WELCOME

Patient Information

Name		Nickname	
Street Address	City	State	Zip Code
Home Phone	Cell Phone	Social Security Number	
Birthdate	Sex	Marital Status	
Patient's Employer		Occupation	Business Phone
Spouse Name	Birthdate	Employer	
Father's Name (if minor)		Mother's Name (if minor)	
Father's Employer (if minor)		Mother's Employer (if minor)	
Home Phone	Business Phone	Home Phone	Business Phone
Person Responsible for account		Relationship to patient	
In case of Emergency who should we contact?		Relationship to patient	Phone
Whom may we thank for your referral to this office?		What is the reason for your visit today?	

Primary Insurance

Subscriber Name	Social Security Number	Birthdate	Relationship to Patient
Subscriber Employer		Occupation	Business Phone
Insurance Company		Insurance Phone	Group Number

Secondary Insurance

Subscriber Name	Social Security Number	Birthdate	Relationship to Patient
Subscriber Employer		Occupation	Business Phone
Insurance Company		Insurance Phone	Group Number

Health History

Medical Physician's Name
Are you presently under the care of a physician? ◯Yes ◯No
If yes, what is the condition or nature of illness?
Have you ever had a blood transfusion? ◯Yes ◯No

Medications

Please list medications you are currently taking (including over the counter drugs):
Please list any drugs, medications or materials you are *allergic* to:

Health History Continued

Have you ever had or been treated for any of the following conditions or diseases? (check all that apply)		
☐ AIDS/ARC/HIV	☐ Fainting	☐ Nervous disorders
☐ Anemia	☐ Glaucoma	☐ Pacemaker
☐ Arthritis	☐ Heart murmur	☐ Radiation treatment
☐ Artificial heart valves	☐ Heart problems	☐ Respiratory disease
☐ Artificial joints	☐ Hemophilia	☐ Rheumatic fever
☐ Asthma	☐ Hepatitis A – B – C	☐ Scarlet fever
☐ Blood disease	☐ High/Low Blood Pressure	☐ Shortness of breath
☐ Chemical dependency	☐ Jaw Pain	☐ Sinus problems
☐ Chemotherapy	☐ Kidney/Bladder disease	☐ Stroke
☐ Diabetes	☐ Liver disease	☐ Typhoid fever
☐ Diverticulitis/Colitis	☐ Malignancies (cancers)	☐ Tonsilitis
☐ Dizziness	☐ Measles	☐ Tuberculosis
☐ Epilepsy	☐ Mitral Valve Prolapse	☐ Ulcers
☐ Excessive bleeding	☐ Mumps	☐ Other
For women only:		
Is there a possibility that you may be pregnant? ◯ Yes ◯ No		Are you nursing? ◯ Yes ◯ No

Dental History

Have you ever experienced a problem with local anesthesia?	◯ Yes	◯ No		
Do you have an allergy to anesthesia?	◯ Yes	◯ No		
Do you have any discomfort in your mouth presently?	◯ Yes	◯ No		
Please ŏKŝŏ] the following as it applies to your teeth:	◯ Sensitive to heat	◯ Sensitive to cold	◯ Sensitive to sweets	◯ Sensitive to chewing
Have you ever been in an accident causing injury to your face or neck?	◯ Yes	◯ No		
Please ŏKŝŏ] the following as it applies to your jaw:	◯ Pain	◯ Clicking	◯ Popping	◯ No problems
Have you ever had TMJ treatment?	◯ Yes	◯ No		
Have you ever had your teeth straightened?	◯ Yes	◯ No		
How often do you brush your teeth?	x per day			
How often do you floss?	x per week			
Have you ever been diagnosed as having periodontal disease?	◯ Yes	◯ No		
Do you grind or clench your teeth?	◯ Yes	◯ No		
Are you aware of any swelling or lumps in your mouth?	◯ Yes	◯ No		
Do your gums bleed when you brush your teeth?	◯ Yes	◯ No		
Do you get frequent blisters on the lips or mouth?	◯ Yes	◯ No		
Are you aware of any oral habits (please ŏKŝŏ]ú }	◯ Thumb sucking	◯ Nail biting	◯ Mouth breathing	
Date of last dental cleaning				
Date of last full mouth x-rays				
Do you have a DNR (do not resuscitate)?	◯ Yes	◯ No		

Signature (patient, parent or guardian) Date

Authorization

I hereby authorize payment directly to the Dental Office of the insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are corrent to best of my knowledge.

Signature (patient, parent or guardian) Date

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