Welcome to our office!

Please take a moment to share with us your information…

Patient Name: ______________________ Preferred name/nickname: ______________

Home address/City/State/Zip Code: ______________________________________

____

Home telephone number: ______________ Work phone: ______________________

Cell Phone: ______________________ Email address: ______________________

Age: _____ Date of birth: ________ Gender ________ Social security number: ______________

Your occupation: ______________________ Marital Status: ______________________

If you are a student, please list the school you are attending: ______________________

How did you hear about our practice? ______________________________________

Hobbies/interests: ____

Parent/Guardian information…

Name: ______________________ Relationship to Patient: ______________________

Home address/City/State/Zip Code: ______________________________________

____

Home telephone number: ______________ Work phone: ______________________

Cell Phone: ______________________ Email address: ______________________

Date of birth: ______________________ Social security number: ______________________

Your occupation: ______________________ Marital Status: ______________________

Insurance information…

Do you have dental insurance? ______________ Primary card holder's name: ______________

Primary card holder's employer: ______________ Insurance company name: ______________

Insurance company phone number: ______________ Insurance company group number: ______________

Primary card holder's date of birth: ______________ Primary card holder's social: ______________

Please list the member or subscriber ID number if one is provided: ______________________

Your relationship to the card holder: Self Spouse Child

Primary Emergency contact information…

Whom may we notify in case of an emergency? ______________________________

Relationship to patient: ______________________ Best contact number: ______________________

Address: ____

In case we cannot reach your primary emergency contact person…

Who ELSE may we notify in case of an emergency? ______________________________

Relationship to patient: ______________________ Best contact number: ______________________

Address: ____

Medical History

Please answer the following questions so that we may provide optimum care for you…

Are you currently under the care of a medical doctor? ____________________

If so, please provide the Doctors name and reason for care: ____________________

____

Are you currently taking any prescription drugs? Please list: ____________________

____

Do you have any allergies? Please list: ____________________

Are you pregnant or suspect you may be pregnant? __________ Do you take birth control? __________

Have you had any major surgeries in the last five years? ______ If yes, please provide the date and description of your surgery: ____________________

Do you have pins, plates, screws, or artificial joints? ____________________

Have you ever been informed of a heart murmur, condition, or had heart surgery? Please explain in detail: __________

____

Have you ever bled excessively? __________ Have you ever had complications with anesthesia? __________

Do you smoke or use tobacco? Yes No

Please circle any of the following and provide a date if you have had or currently have:

High/low blood pressure:	Rheumatic Fever:	Glaucoma (wide or narrow?):	Angina Pectoris:	
Tuberculosis:	Chemotherapy:	Mitrovalve Prolapse:	Liver Disease:	HIV:
AIDS:	Hepatitis A, B, or C:	Chest pain:	Yellow Jaundice:	Anemia:
Blood Transfusion:	Hemophilia:	Sickle Cell Disease:	Kidney Trouble:	Stroke:
Congenital Heart Lesions:	Scarlet Fever:	Hay Fever:	Narcotic addiction:	Hives:
Sinus Trouble:	Asthma:	Emphysema:	Arthritis:	
Rheumatism:	Cortisone Meds:	Psychiatric Treatment:	Drug Addictions:	Epilepsy:
Fainting:	Nervousness:	Eating Disorder:	Diabetes:	
Thyroid Disease:	Ulcers: Cold Sores:	X-ray or Cobalt Treatment:	bisphosphonates (osteoporosis):	

Is there anything that has not been covered on this form that you would like to share with us regarding your overall medical history? ____________________

The information I have given today is true and correct to the best of my knowledge. I will inform the doctor/assistant if there is any change in my medical or dental status.

____

Patient Signature (*aged 18 and over*): Date: Doctor's Signature: Date:

____

Parent/Guardian Signature: Date: Doctor's Signature: Date:

Dental History

Please answer the following questions so that we may provide optimum care for you…

What concerns you about the way your teeth look? ____

____

How long has it been since your last dental visit?____________ Were dental x-rays taken? ________________________

General Dentist's name: ____________________________ General Dentist's phone number: __________________

Was there any recommended dental treatment not completed? ____

Have you ever been evaluated for Orthodontic treatment? Yes No If yes, when? ________________________

Have you ever sucked your thumb or finger? Yes No If yes, from __________ to ___________

Do you feel nervous about having treatment? Yes No

Have you ever had an unpleasant experience at a dental office? Yes No

Are your teeth sensitive to: Heat Cold Biting Pressure Sweets

Does your jaw pop or click? Yes No Do you have frequent headaches? Yes No

Do you ever have pain in your jaw region? Yes No

Have you ever had braces or other orthodontic treatment? Yes No If yes, from __________ to __________

Have you ever had or been recommended for speech therapy? Yes No If yes, when _______________

Does food constantly get stuck between your teeth? Yes No

Do you brush daily? Yes No Do your gums ever bleed when you brush? Yes No

Do you floss daily? Yes No Do your gums ever bleed when floss? Yes No

Is there ever an unpleasant taste or odor in your mouth? Yes No Do you smoke or use tobacco? Yes No

In general, how do you feel about your overall dental health? ____

Is there anything that has not been covered on this form that you would like to share with us regarding your overall dental history? ____

The information I have given today is true and correct to the best of my knowledge. I will inform the doctor/assistant if there is any change in my medical or dental status.

____

Patient Signature (*aged 18 and over*): Date: Doctor's Signature: Date:

____

Parent/Guardian Signature: Date: Doctor's Signature: Date: