PATIENT INFORMATION

PATIENT # _____

NAME _____ BIRTHDATE _____ TODAY'S DATE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE ____

HOME PHONE_____ CELL PHONE _____ WORK PHONE _____ ZIP _____

PLEASE CHECK ONE ___ MINOR ___SINGLE ___MARRIED ___DIVORCED ___ WIDOWED ___ SEPARATED

PATIENT'S EMPLOYER _____
(PARENT/GUARDIAN IF MINOR)

WHOM MAY WE THANK FOR REFERRING YOU? _____

EMERGENCY CONTACT _____ PHONE _____
RELATIONSHIP

RESPONSIBLE PARTY

NAME OF RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY_____ STATE_____ ZIP_____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMPLOYER _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

I AGREE TO BE RESPONSIBLE FOR ALL COSTS RELATED TO THE PATIENT'S DENTAL TREATMENT, INCLUDING COSTS ASSOCIATED WITH COLLECTION OF UNPAID DEBT.

SIGNATURE _____ ***DATE***_____

DENTAL INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT_____

BIRTHDATE _____ SSN/ ID # _____ GROUP # _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____

INSURANCE COMPANY _____

INSURANCE CO. ADDRESS _____

DO YOU HAVE SECONDARY DENTAL INSURANCE? ☐ YES ☐ NO

PLEASE PROVIDE THE FRONT DESK WITH A COPY OF YOUR INSURANCE CARD

PLEASE ALLOW 24 HOURS NOTICE FOR ALL CANCELLATIONS
TO AVOID A $75 BROKEN APPOINTMENT FEE

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PATIENT MEDICAL HISTORY

PHYSICIAN _____ **OFFICE PHONE** _____ **DATE OF LAST EXAM** _____

	YES	NO		YES	NO
ARE YOU UNDER MEDICAL CARE NOW?			ARE YOU ALERGIC TO LATEX?		
HAVE YOU BEEN HOSPITALIZED IN THE LAST 2 YEARS? WHY? _____			HAVE YOU EVER HAD A SENSITIVITY OR REACTION TO DENTAL ANESTHETICS?		
DO YOU HAVE A CONDITION THAT REQUIRES PRE-MEDICATION FOR DENTAL APPOINTMENTS?			ARE YOU ALLERGIC TO ANY MEDICATIONS? IF SO, WHAT? _____		
DO YOU USE TOBACCO? DO YOU USE ALCOHOL? DO YOU USE OTHER DRUGS?			ARE YOU TAKING ANY MEDICATIONS? IF SO, PLEASE LIST: _____ _____		

DO YOU HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
HIGH BLOOD PRESSURE			ANEMIA			STROKE		
LOW BLOOD PRESSURE			EMPHYSEMA			ALLERGIES /HAY FEVER		
HEART CONDITION			CANCER			TUBERCULOSIS		
FAINTING / SEIZURES			ARTHRITIS			RADIATION THERAPY		
LEUKEMIA			JOINT REPLACEMENT			GLAUCOMA		
DIABETES			HEPATITIS			RECENT WEIGHT LOSS		
KIDNEY DISEASE			SEXUALLY TRANSMITTED DISEASE			LIVER DISEASE		
AIDS OR HIV INFECTION			STOMACH TROUBLES			RESPIRATORY PROBLEMS		

IF YOU ANSWERED YES TO ANY OF THE PREVIOUS CONDITIONS, PLEASE EXPLAIN:

_____

_____

_____

PATIENT DENTAL HISTORY

	YES	NO		YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?			HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES?		
ARE YOUR TEETH SENSITIVE TO HOT OR COLD?			HAVE YOU EVER HAD ORTHODONTIC WORK?		
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR?			HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS?		
DO YOU CLENCH OR GRIND YOUR TEETH?			DO YOU BITE YOUR CHEEKS OR LIPS FREQUENTLY?		
DO YOU EVER EXPERIENCE JAW JOINT PROBLEMS?			DO YOU EXPERIENCE FREQUENT DRY MOUTH?		

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ANSWERED ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

_____ _____

SIGNATURE (PATIENT, PARENT, OR GUARDIAN) TODAY'S DATE

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