

# Welcome!

We are pleased to welcome you to our practice. Please take a few moments to fill out this form as completely as possible. If you have questions we'll be happy to help you. We look forward to working with you in maintaining your dental health.



Today's Date: \_\_\_\_\_

## PATIENT INFORMATION

Social Security Number: \_\_\_\_\_

Home Phone No.: \_\_\_\_\_

Cellular/Pager No.: \_\_\_\_\_

Work Phone No.: \_\_\_\_\_

Mr. / Mrs. / Ms. / Dr. (circle one)

Patient Name: \_\_\_\_\_  
Last First Initial Preferred Name

Street Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail: \_\_\_\_\_ Sex: \_\_\_M\_\_\_F Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Separated \_\_\_ Divorced \_\_\_

Occupation \_\_\_\_\_ Patient Employer/School: \_\_\_\_\_

Employer address: \_\_\_\_\_

Employer Phone No.: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SS/HC/Patient ID Number: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_ Marital Status \_\_\_\_\_

Mailing Address Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Driver License # \_\_\_\_\_ State \_\_\_\_\_

SS/HC/Patient ID# \_\_\_\_\_ Birthdate: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Employer Name & Address: \_\_\_\_\_ Years Employed: \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

Insured's Name: \_\_\_\_\_

Insured's SS# or ID#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Group Policy Number: \_\_\_\_\_

Insurance Co: \_\_\_\_\_

Insurance Co: Phone No: \_\_\_\_\_

Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

## IN CASE OF EMERGENCY, CONTACT (RELATIVE NOT LIVING WITH YOU)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone No.: \_\_\_\_\_ Cell/Pager No.: \_\_\_\_\_ Work No.: \_\_\_\_\_

# DENTAL AND HEALTH HISTORY

Confidential

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Birth date: \_\_\_\_\_

## DENTAL HISTORY

Reason for Today's Visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_  
Former Dentist \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_  
Address: \_\_\_\_\_

Mark (X) if you have had problems with any of the following:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Bad breath                     | <input type="checkbox"/> Grinding teeth                | <input type="checkbox"/> Sensitivity to hot    |
| <input type="checkbox"/> Bleeding gums                  | <input type="checkbox"/> Loose teeth                   | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw        | <input type="checkbox"/> Periodontal treatment         | <input type="checkbox"/> Sensitivity to biting |
| <input type="checkbox"/> Food collection between teeth  | <input type="checkbox"/> Broken fillings               | <input type="checkbox"/> Sensitivity to cold   |
| <input type="checkbox"/> Sores or growths in your mouth | <input type="checkbox"/> Previous orthodontics(braces) |  |

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_  
Have you been taught how to control dental plaque? \_\_\_\_\_ Special devices used: \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_  
Have you had any serious illnesses or operations? \_\_\_\_\_ if yes, please describe \_\_\_\_\_

Mark (X) if you have or have had any of the following:

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Cough                | <input type="checkbox"/> HIV/ AIDS             | <input type="checkbox"/> Sinus Problems      |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Skin Condition      |
| <input type="checkbox"/> Artificial joints      | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Stomach Problems    |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Bleeding disorder      | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Thyroid Problems    |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Pregnant              | <input type="checkbox"/> Tobacco Use         |
| <input type="checkbox"/> Chemical Dependency    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Radiation             | <input type="checkbox"/> Ulcer               |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Other               |

Details: \_\_\_\_\_

### MEDICATIONS

List Medications Currently Taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_

### ALLERGIES

Aspirin  Penicillin  
 Codeine  Sulfa  
 Novocain  Latex  
 Other \_\_\_\_\_

**\*\*Medical/Dental Hx Reviewed: \_\_\_\_\_\*\***

## SIGNATURE

I understand all of the above information is necessary to provide me with dental care in a safe and efficient manner. To the best of my knowledge, the above information is complete and correct. I also understand that it is my responsibility to inform the staff of any changes in my or my minor child's health.

Patient, Parent, or Personal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_