



# PATIENT INFORMATION

## PATIENT INFORMATION

| PATIENT FIRST NAME: | MI: | PATIENT LAST NAME: | PATIENT SOCIAL SECURITY NO.: | TODAY'S DATE: |
|---|---|---|---|---|
| | | | ___ – ___ – ____ | |

| ADDRESS: | CITY: | STATE/ZIP CODE: | DRIVER'S LICENSE NO.: |
|---|---|---|---|
| | | | |

| HOME PHONE: | WORK PHONE: | CELLULAR PHONE: | E-MAIL: |
|---|---|---|---|
| | | | ☐ I would like to receive correspondence via e-mail |

| DATE OF BIRTH: | AGE: | GENDER: | MARITAL STATUS: |
|---|---|---|---|
| | | ☐ Male ☐ Female | ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed |

**EMPLOYMENT/STUDENT STATUS:**

STUDENT: ☐ Full Time ☐ Part Time
EMPLOYMENT: ☐ Full Time ☐ Part Time ☐ Retired

**PERSON FINANCIALLY RESPONSIBLE FOR SERVICES:**

☐ Patient is the responsible party for payment for dental services
☐ Patient is a policy-holder of responsible party

## CONTACT IN CASE OF EMERGENCY

| NAME: | HOME PHONE: | WORK OR CELL PHONE: | RELATIONSHIP: |
|---|---|---|---|
| | | | |

## RESPONSIBLE PARTY

(Please complete only if responsible party is someone other than the patient)

| FIRST NAME: | MI | LAST NAME: | SOCIAL SECURITY NO.: | DATE OF BIRTH: |
|---|---|---|---|---|
| | | | ___ – ___ – ____ | |

| ADDRESS: | CITY: | STATE/ZIP CODE: | DRIVER'S LICENSE NO.: |
|---|---|---|---|
| | | | |

| HOME PHONE: | WORK PHONE: | CELLULAR PHONE: | RELATIONSHIP TO PATIENT: |
|---|---|---|---|
| | | | |

## DENTAL INSURANCE INFORMATION

### PRIMARY INSURANCE

| NAME OF INSURED: | RELATIONSHIP TO PATIENT: |
|---|---|
| | |

| SOCIAL SECURITY NO.: | DATE OF BIRTH: |
|---|---|
| ___ – ___ – ____ | |

| EMPLOYER: | INSURANCE COMPANY: |
|---|---|
| | |

| ADDRESS: | | |
|---|---|---|
| | | |

| CITY: | STATE/ZIP: |
|---|---|
| | |

| EMPLOYER PHONE: | EMPLOYER ID: | GROUP#: |
|---|---|---|
| | | |

### SECONDARY INSURANCE

| NAME OF INSURED: | RELATIONSHIP TO PATIENT: |
|---|---|
| | |

| SOCIAL SECURITY NO.: | DATE OF BIRTH: |
|---|---|
| ___ – ___ – ____ | |

| EMPLOYER: | INSURANCE COMPANY: |
|---|---|
| | |

| ADDRESS: | | |
|---|---|---|
| | | |

| CITY: | STATE/ZIP: |
|---|---|
| | |

| EMPLOYER PHONE: | EMPLOYER ID: | GROUP#: |
|---|---|---|
| | | |



# PATIENT MEDICAL HISTORY

**PATIENT NAME:** _____ **DATE:** _____

***PLACE A MARK ON "Yes" OR "No" TO INDICATE ANY OF THE FOLLOWING:***

Are you under the care of a physician?
☐ *No* ☐ *Yes* If yes, please explain: _____

Do you have any general health problems?
☐ *No* ☐ *Yes* If yes, please list: _____

Are you currently taking any drugs or medications?
☐ *No* ☐ *Yes* If yes, please list: _____

Are you allergic to any medications?
☐ *No* ☐ *Yes* If yes, please list: _____

What is the name of your pharmacy? _____

***PLACE A MARK ON "Yes" OR "No" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:***

| | *No* | *Yes* | | *No* | *Yes* | | *No* | *Yes* |
|---|---|---|---|---|---|---|---|---|
| AIDS | ☐ | ☐ | Fainting or dizziness | ☐ | ☐ | Psychiatric Care | ☐ | ☐ |
| Anemia | ☐ | ☐ | Glaucoma | ☐ | ☐ | Radiation Treatment | ☐ | ☐ |
| Arthritis, Rheumatism | ☐ | ☐ | Hay Fever | ☐ | ☐ | Respiratory Disease | ☐ | ☐ |
| Artificial Heart Valves | ☐ | ☐ | Headaches | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ |
| Artificial Joints | ☐ | ☐ | Head Injuries | ☐ | ☐ | Scarlet Fever | ☐ | ☐ |
| Asthma | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Shortness of Breath | ☐ | ☐ |
| Back Problems | ☐ | ☐ | Heart Problems | ☐ | ☐ | Sinus Problem | ☐ | ☐ |
| Bleeding Abnormally, after extractions or surgery | ☐ | ☐ | Hepatitis - Type: ☐ | ☐ | ☐ | Skin Rash | ☐ | ☐ |
| Blood Disease | ☐ | ☐ | Herpes | ☐ | ☐ | Special Diet | ☐ | ☐ |
| Cancer | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Stomach Problem | ☐ | ☐ |
| Chemical Dependency | ☐ | ☐ | HIV Positive | ☐ | ☐ | Stroke | ☐ | ☐ |
| Chemotherapy | ☐ | ☐ | Jaundice | ☐ | ☐ | Swelling of Feet or Ankle | ☐ | ☐ |
| Circulatory Problems | ☐ | ☐ | Jaw Pain | ☐ | ☐ | Swollen Neck Glands | ☐ | ☐ |
| Congenital Heart Lesion | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Thyroid Problems | ☐ | ☐ |
| Cortisone Treatments | ☐ | ☐ | Liver Disease | ☐ | ☐ | Tonsillitis | ☐ | ☐ |
| Cough, persistent or bloody | ☐ | ☐ | Low Blood Pressure | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | Tumor or Growth on Head or Neck | ☐ | ☐ |
| Emphysema | ☐ | ☐ | Nervous Problems | ☐ | ☐ | Ulcer | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | Pacemaker | ☐ | ☐ | Venereal Disease | ☐ | ☐ |
| Do you wear contact lenses? | ☐ | ☐ | Women: Are you pregnant? | ☐ | ☐ | Unexplained Weight Loss? | ☐ | ☐ |
| | | | Date Due? _____. | | | | | |
| | | | Are you nursing? | ☐ | ☐ | | | |

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____



# PATIENT DENTAL HISTORY

**PATIENT NAME:** _____ **DATE:** _____

***PLACE A MARK ON "Yes" OR "No" TO INDICATE ANY OF THE FOLLOWING:***

| | | | | |
|---|---|---|---|---|
| 1 | Are your teeth sensitive to: | | 2 | Does your food get stuck between certain teeth in your mouth? |
| | | *NO* *YES* | | |
| | Heat? | ☐ ☐ | | |
| | Sweet? | ☐ ☐ | | Occasionally? ☐ ☐ |
| | Cold? | ☐ ☐ | | Constantly? ☐ ☐ |
| | Biting Pressure? | ☐ ☐ | | |

| | | *NO* | *YES* | |
|---|---|---|---|---|
| 3 | Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? | ☐ | ☐ | 3 |
| 4 | Are you dissatisfied with your teeth in any way? | ☐ | ☐ | 4 |
| 5 | Are you dissatisfied with the way your teeth look? (For example: color, shape, spaces, etc.) | ☐ | ☐ | 5 |
| 6 | Do you have any fillings that show in your front teeth? | ☐ | ☐ | 6 |
| 7 | Do any of your fillings show when you smile? | ☐ | ☐ | 7 |
| 8 | Do you have loose teeth or broken fillings? | ☐ | ☐ | 8 |
| 9 | If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, conservative tooth-colored restoration instead? | ☐ | ☐ | 9 |
| 10 | Have you ever had any teeth removed? | ☐ | ☐ | 10 |
| 11 | Do your gums bleed when brushing? | ☐ | ☐ | 11 |
| 12 | Do you ever avoid any part of the mouth while brushing? | ☐ | ☐ | 12 |
| 13 | Have you been instructed regarding proper home care? | ☐ | ☐ | 13 |
| 14 | Do you have an unpleasant taste or odor in your mouth? | ☐ | ☐ | 14 |
| 15 | Do you smoke? | ☐ | ☐ | 15 |
| 16 | Do you use chewing tobacco? | ☐ | ☐ | 16 |
| 17 | Do you chew on one side of your mouth? | ☐ | ☐ | 17 |
| 18 | Have you ever been told that you grind your teeth? | ☐ | ☐ | 18 |
| 19 | Do you frequently snack between meals on sweets or chewing gum? | ☐ | ☐ | 19 |
| 20 | Do you brush your teeth daily? | ☐ | ☐ | 20 |
| 21 | Do you floss daily? | ☐ | ☐ | 21 |
| 22 | Do you want to learn to control dental disease and retain your teeth? | ☐ | ☐ | 22 |
| 23 | Has the fear of discomfort kept you from regular dental visits? | ☐ | ☐ | 23 |
| 24 | Is it a high priority for you to keep your natural teeth? | ☐ | ☐ | 24 |

| | | |
|---|---|---|
| 25 | Name of your last dentist: _____ | **Phone:** _____ |
| 26 | When was your last dental appointment? _____ | |
| 27 | What did you have done? _____ | |
| 28 | How long since your last thorough examination with full mouth x-rays? _____ | |
| 29 | Why did you leave your last dentist? _____ | |
| 30 | What is the reason for today's visit? _____ | |