



Patient Information (Please complete both sides)

Date
Name (Mr. Mrs. Ms. Dr.)
Home address
City State Zip
Home/Cell phone
email
Birthdate Age
Soc. sec. #
Spouse's name
Birthdate Age
Social Security #
Responsible party if patient is a minor
College attending

EMPLOYMENT

Occupation
Employer name
Work address
City State Zip
Work phone
email

SPOUSE'S EMPLOYMENT

Occupation
Employer name
Work address
City State Zip
Phone number

Insurance Information If you have dental insurance, please complete the following and apprise us as any changes occur in your coverage.

PRIMARY DENTAL COVERAGE

SECONDARY DENTAL COVERAGE

Subscriber name
Insurance company
Insurance company address
Group or policy #
Subscriber ID#

Subscriber name
Insurance company
Insurance company address
Group or policy #
Subscriber ID#

ASSIGNMENT & RELEASE

I recognize that I am financially responsible for any services rendered to me at this office. As a special service to me, insurance claims may be prepared and submitted on my behalf. I hereby authorize this office to release any information to my insurance company that is needed for the filing of my claims.

Signature

Date

Dental History

Referred by
Current dentist How long?
Previous dentist City

When was your last cleaning?
How many cleanings per year?
Have you had recent xrays?

Dental History (Continued from front)

DO YOU HAVE OR HAVE YOU EVER HAD (Please circle)

Head or neck injuries	Yes / No	Trouble opening or closing mouth	Yes / No	Problems of the TMJ (jaw joint)	Yes / No
Sensitive teeth	Yes / No	Prolonged bleeding after extractions	Yes / No	Dissatisfaction with the appearance of your teeth	Yes / No
Grinding or clenching teeth	Yes / No	Orthodontic treatment (braces)	Yes / No		
Difficulty chewing	Yes / No	Periodontal disease (Pyorrhea)	Yes / No		

Medical History

Primary physician _____ How long? _____ Specialty _____
 Office address _____ Phone number _____
 Secondary physician _____ How long? _____ Specialty _____
 Office address _____ Phone number _____

DO YOU HAVE OR HAVE YOU EVER HAD (Please circle)

- | | | |
|--|---|--|
| 1. Circle any medication you have had an adverse reaction to:
aspirin penicillin
erythromycin tetracycline
codeine sedatives/sleeping pills
dental anesthetics other medications (list) | 18. Thyroid or parathyroid disorder Yes / No | 38. Substance abuse (alcohol, drugs IV) Yes / No |
| 2. Hospitalization for illness or surgery Yes / No | 19. Heart trouble Yes / No | 39. Immune deficiency syndrome (HIV, AIDS) Yes / No |
| 3. Hepatitis Yes / No | 20. Heart murmur Yes / No | 40. Asthma Yes / No |
| 4. Jaundice (yellow skin and eyes) Yes / No | 21. Prosthetic heart valve Yes / No | |
| 5. Epilepsy Yes / No | 22. Prosthetic joint (hip or knee) Yes / No | |
| 6. Arthritis Yes / No | 23. Arteriosclerosis Yes / No | |
| 7. Venereal disease Yes / No | 24. High blood pressure Yes / No | |
| 8. Rheumatic fever Yes / No | 25. Low blood pressure Yes / No | |
| 9. Scarlet Fever Yes / No | 26. Persistently swollen ankles Yes / No | |
| 10. Anemia or other blood disorder Yes / No | 27. A stroke Yes / No | |
| 11. Prolonged bleeding due to slight cut Yes / No | 28. Shortness of breath on mild exertion Yes / No | |
| 12. Kidney disease Yes / No | 29. Chest pain Yes / No | |
| 13. Diabetes Yes / No | 30. Hives, skin rash, hay fever Yes / No | |
| 14. Stomach or duodenal ulcer Yes / No | 31. Psychiatric treatment Yes / No | |
| 15. Liver disease Yes / No | 32. A tumor or abnormal growth Yes / No | |
| 16. Tuberculosis Yes / No | 33. Radiation treatment by cobalt, radium, xray or any other source Yes / No | |
| 17. Emphysema Yes / No | 34. Glaucoma Yes / No | |
| | 35. Contact lenses Yes / No | |
| | 36. Prostate disorders Yes / No | |
| | 37. Blood transfusions Yes / No | |

ARE YOU

41. Presently being treated for illness Yes / No
 42. Taking any medications (please list) Yes / No
 43. Aware of any recent weight change Yes / No
 44. Often thirsty Yes / No
 45. Urinating more than six times a day Yes / No
 46. Often exhausted or fatigued Yes / No
 47. A smoker Yes / No
 48. Generally a nervous person Yes / No
 49. Often unhappy or depressed Yes / No
 50. Aware of health change in the past year Yes / No

IF FEMALE, ARE YOU NOW

51. Pregnant Yes / No
 52. Taking birth control pills or hormones Yes / No
 53. Presently in menopause "change of life" Yes / No
 54. Past menopause Yes / No

PLEASE EXPLAIN FULLY ANY "YES" ANSWERS ABOVE

If there are any changes in my medical condition or history I will notify the dentist or your office.

Patient Signature _____ Date _____

Reviewed by _____ Date _____
 Reviewed by _____ Date _____
 Reviewed by _____ Date _____