

Patient Information, (Confidential)

Name _____ Home Phone _____ Cell Phone _____
Address _____ Apt. _____ City _____ State _____ Zip _____
E-mail address _____ Soc. Sec. # _____ Birthdate _____
Marital Status _____ Single _____ Married _____ Divorced _____ Widowed _____
If in school what is the name of your school? _____ State _____ Zip _____
Employer _____ Work Phone # _____
Business address _____ City _____ State _____ Zip _____
Spouse's name _____ Employer _____ Phone # _____
Whom may we thank for inviting you to our practice? _____
Personal Physician's name _____ Phone # _____
Person to contact in case of an emergency? _____

Financial Responsible Person

Name of person financially responsible _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Social Security # _____ Birthdate _____ Home Phone # _____
Employer _____ Work Phone # _____
Is this person currently a patient in our practice? Yes / No _____ Cell Phone # _____

Insurance Information

Name of insured _____ Relationship to patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Name of Employer _____ Work Phone # _____
Employer Address _____ City _____ State _____ Zip _____
Name of Insurance Company _____
(Do you have any additional insurance? Yes / No) _____
(If yes, please complete the following)
Name of insured _____ Relationship to patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Name of Employer _____ Work Phone # _____
Employer Address _____ City _____ State _____ Zip _____
Name of Insurance Company _____

Dental Information:

- What is the purpose of your dental visit today? _____
- Y/N Are you having discomfort at this time?
If so, where? _____
- Y/N Have you been treated for Periodontal (Gum) Disease before?
- Y/N Have had a deep cleaning or scaling and root planning before?
- Y/N Do your gums bleed when you brush or floss?
- Y/N Does food catch between your teeth?
- Y/N Are your teeth sensitive to hot?
- Y/N Are your teeth sensitive to biting hard things?
- Y/N Is your mouth dry?
- Y/N Do your jaw joints make noise or hurt?
- Y/N Do you clench or grind your teeth?
- Y/N Do you wear dentures or partial dentures?
- Y/N Have you had a serious injury to your head or mouth?

- Y/N Do you have any loose teeth?
 Y/N Do you have any areas in your mouth where your gum tissue is swollen?
 Y/N Have you had your wisdom teeth removed?
 Y/N Are you happy with your smile?
 When was your last dental exam? _____

Medical Information

Sex: Male / Female If Female, please answer the following:

- Are you taking Birth control pills? Yes / No
 Are you Pregnant? Yes / No If yes how many weeks? _____
 Are you nursing? Yes / No

Do you smoke or use smokeless tobacco? Yes / No If yes how much / day? _____

Please circle Yes/No to indicate if you have or have not had the following diseases or conditions.

- | <u>Condition</u> | <u>Condition</u> |
|---------------------------------|------------------------------------|
| Y/N Abnormal Bleeding | Y/N Hepatitis A |
| Y/N Alcohol or Drug Abuse | Y/N Hepatitis B or C |
| Y/N Anemia | Y/N High Blood Pressure |
| Y/N Arthritis | Y/N Kidney Problems |
| Y/N Artificial Joints | Y/N Leukemia |
| Y/N Artificial Heart Valve | Y/N Liver Problems |
| Y/N Asthma | Y/N Low Blood Pressure |
| Y/N Cancer | Y/N Mitral Valve Prolapse |
| Y/N Chemotherapy | Y/N Osteoporosis / Paget's disease |
| Y/N Congenital Heart Defect | Y/N Pace Maker |
| Y/N Diabetes | Y/N Radiation Therapy |
| Y/N Epilepsy | Y/N Rheumatic Fever |
| Y/N Fainting Spells | Y/N Seizures |
| Y/N Fever Blisters / Cold Sores | Y/N Sickle Cell Disease |
| Y/N Frequent Headaches | Y/N Sinus Problems |
| Y/N HIV / AIDS | Y/N Snore |
| Y/N Heart Attack | Y/N Stroke |
| Y/N Heart Murmur | Y/N Tuberculosis |
| Y/N Heart Surgery | Y/N Thyroid Problems |
| Y/N Hemophilia | Y/N Ulcers |

- | <u>Allergies</u> | <u>Allergies</u> |
|-----------------------|--------------------|
| Y/N Aspirin | Y/N Metals |
| Y/N Codeine | Y/N Penicillin |
| Y/N Dental Anesthetic | Y/N Tetracycline |
| Y/N Erythromycin | Y/N Dyes |
| Y/N Jewelry | Y/N Food Colorings |
| Y/N Latex | Other: _____ |

Are you taking any of the following Medications?

- | | |
|---|--------------------------|
| Y/N Actonel, Aredia, Boniva, Didronel, Fosamax, Skelid, or Zometa | Y/N Insulin |
| Y/N Antibiotics | Y/N Nitroglycerine |
| Y/N Aspirin | Y/N Pain Medication |
| Y/N Antihistamines | Y/N Steroids |
| Y/N Blood Thinners | Y/N Tranquilizers |
| Y/N Heart Medication | Other Medications? _____ |
| Y/N High Blood Pressure | |