PATIENT INFORMATION CONFIDENTIAL

DATE: ________________

NAME: ____ BIRTHDATE: ________________ SSN#/SIN: _________________
FIRST MI LAST MM/DD/YYYY

ADDRESS: _______________________________________ CITY: _______________________ STATE: _______ ZIP: _________

E-MAIL: _______________________ PRIMARY PHONE: ___________________ SECONDARY PHONE: ___________________
CIRCLE ONE: HOME/CELL/WORK HOME/CELL/WORK

CHECK APPROPRIATE SELECTION: ___ MINOR ___ SINGLE ___ MARRIED ___ DIVORCED ___ SEPARATED ___ OTHER

PATIENT/GUARDIAN'S EMPLOYER: _______________________ HOW DID YOU HEAR ABOUT US? _____________________

SPOUSE OR PARENT/GUARDIAN'S NAME: ________________________________ DRIVER'S LICENSE # __________________

EMERGENCY CONTACT: ____________________________ RELATIONSHIP: _______________ PHONE: __________________

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: _________________________________ RELATIONSHIP: ___________

___ SAME INFORMATION AS ABOVE ADDRESS: ____

PHONE NUMBER(S): ____ E-MAIL: __________________________________

BIRTHDATE: ______________ EMPLOYER: __________________________________ DRIVER'S LICENSE # _________________

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

INSURANCE INFORMATION

NAME OF INSURED: ____ RELATIONSHIP TO PATIENT: ________________

EMPLOYER: _________________________________ INSURANCE COMPANY NAME: _________________________________

INSURANCE CO ADDRESS: ____ PHONE # ___________________

SUBSCRIBER SSN OR ID# _______________________ SUBSCRIBER DATE OF BIRTH: ______________ GROUP # ___________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ___ YES ___ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED: ____ RELATIONSHIP TO PATIENT: ________________

EMPLOYER: _________________________________ INSURANCE COMPANY NAME: _________________________________

INSURANCE CO ADDRESS: ____ PHONE # ___________________

SUBSCRIBER SSN OR ID# _______________________ SUBSCRIBER DATE OF BIRTH: ______________ GROUP # ___________

X ____ ___________________ ___________________
SIGNATURE OF PATIENT OR GUARDIAN DATE RELATIONSHIP

PATIENT MEDICAL HISTORY

PATIENT NAME: ______________________ DATE OF BIRTH: ______________ TODAY'S DATE: ______________

PHYSICIAN: ______________________ OFFICE PHONE: ______________ DATE OF LAST EXAM: ____________

	YES	NO
ARE YOU UNDER MEDICAL TREATMENT NOW?	❐	❐
HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	❐	❐
ARE YOU TAKING ANY MEDICATIONS? PLEASE LIST: ______________________	❐	❐

____

____

	YES	NO
DO YOU TAKE BLOOD THINNERS?	❐	❐
HAVE YOU TAKEN BISPHOSPHONATES? (BONE STRENGTHENING MEDICATIONS)	❐	❐
DO YOU USE ALCOHOL?	❐	❐
DO YOU USE TOBACCO?	❐	❐
ARE YOU WEARING CONTACT LENSES?	❐	❐

ARE YOU ALLERGIC OR HAVE YOU HAD ANY REACTIONS TO THEFOLLOWING?

YES	NO		YES	NO	
❐	❐	LOCAL ANESTHETICS	❐	❐	SULFA DRUGS
❐	❐	SEDATIVES	❐	❐	ASPIRIN
❐	❐	IODINE	❐	❐	LATEX
❐	❐	PENICILLIN OR OTHER ANTIBIOTICS			

PLEASE SPECIFY: ______________________

❐ ❐ FOODS PLEASE SPECIFY: ______________________

❐ ❐ OTHER: ______________________

	YES	NO
DO YOU HAVE A PERSISTANT COUGH OR THROAT CLEARING, NOT ASSOCIATED WITH A KNOWN ILLNESS?	❐	❐

WOMEN ONLY:

	YES	NO
ARE YOU PREGANT OR THINK YOU MAY BE?	❐	❐
ARE YOU NURSING?	❐	❐
ARE YOU TAKING BIRTH CONTROL PILLS?	❐	❐

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

YES	NO		YES	NO		YES	NO	
❐	❐	AIDS OR HIV INFECTION	❐	❐	FAINTING	❐	❐	LOW BLOOD PRESSURE
❐	❐	ANEMIA	❐	❐	FREQUENTLY TIRED	❐	❐	RADIATION THERAPY
❐	❐	ANGINA	❐	❐	GLAUCOMA	❐	❐	RESPIRATORY PROBLEMS
❐	❐	ARTHRITIS	❐	❐	HAY FEVER/ALLERGIES	❐	❐	RHEUMATIC FEVER
❐	❐	ARTIFICAL HEART VALVE	❐	❐	HEART ATTACK	❐	❐	STD/STI
❐	❐	ASTHMA	❐	❐	HEART DISEASE	❐	❐	STOMACH TROUBLES/ULCERS
❐	❐	CANCER	❐	❐	HEART MURMUR	❐	❐	STROKE
❐	❐	CARDIAC PACEMAKER	❐	❐	HEPATITIS	❐	❐	SWOLLEN ANKLES
❐	❐	CHEST PAINS	❐	❐	HIGH BLOOD PRESSURE	❐	❐	THYROID CONDITION
❐	❐	DIABETES	❐	❐	JOINT REPLACEMENT	❐	❐	TUBERCULOSIS
❐	❐	EASILY WINDED	❐	❐	KIDNEY DISEASE	❐	❐	OTHER______________
❐	❐	EMPHYSEMA/COPD	❐	❐	LEUKEMIA			______________________
❐	❐	EPILEPSY/SEIZURES	❐	❐	LIVER DISEASE			______________________

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING & FLOSSING?	❐	❐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD?	❐	❐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR?	❐	❐
DO YOU FEEL PAIN IN ANY OF YOUR TEETH?	❐	❐
HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES?	❐	❐
DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	❐	❐
DO YOU HAVE FREQUENT HEADACHES?	❐	❐
HAVE YOU HAD ANY ORTHODONTIC WORK?	❐	❐
HISTORY OF DIFFICULT EXTRACTIONS?	❐	❐
HISTORY OF PROLONGED BLEEDING WITH EXTRACTIONS?	❐	❐

HAVE EVER EXPERIENCED ANY OF THE FOLLOWING:	YES	NO
CLICKING IN JAW?	❐	❐
PAIN IN JOINT, EAR, OR SIDE OF FACE?	❐	❐
DIFFICULTY IN OPENING OR CLOSING?	❐	❐
DIFFICULTY IN CHEWING?	❐	❐
DO YOU HAVE ANY LUMPS OR SORES IN YOUR MOUTH?	❐	❐
DO YOU CLENCH OR GRIND YOUR TEETH?	❐	❐
HAVE YOU HAD INSTRUCTION ON PROPER BRUSHING?	❐	❐
HAVE YOU HAD INSTRUCTION ON FLOSSING?	❐	❐

APPROXIMATE DATE OF LAST CLEANING______________________

X ______________________________ ______________ ______________

SIGNATURE OF PATIENT OR GUARDIAN DATE RELATIONSHIP