

## Patient Information

A B C

Date	_____		
Patient's Name	_____		
	Last	First	Middle
Address	_____		
	Street	City	State
Home Phone	_____		Zip
	Birthdate	Social Security #	
If patient is a minor, give parent's or guardian's name _____			
Whom may we thank for referring you to our office? _____			

## Responsible Party Information

Name	_____			Marital Status	_____
	Last	First	Middle		
Residence	_____				
	Street	City	State	Zip	
Mailing Address	_____				
	Street	City	State	Zip	
How long at this address	_____		Home Phone	Work Phone	
Previous Address (if less than 3 yrs.) _____					
Social Security #	_____		Birthdate	Relationship to Patient	
	Street	City	State	Zip	
Employer	_____		Occupation	No. Years Employed	
Spouse's Name	_____			Relationship to Patient	
	Last	First	Middle		
Employer	_____		Occupation	No. Years Employed	
Social Security #	_____		Birthdate	Work Phone	

## Insurance Information

Insured's Name	_____			Insured's Soc. Sec. #	_____
Insurance Company	_____		Group No.	Local No.	
Insurance Co. Address _____					
Do you have dual coverage? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes: Insurance Co. Phone # _____					
Insured's Name	_____			Insured's Soc. Sec. # _____	
Insurance Co.	_____		Group No.	Local No.	
Insurance Co. Address _____					
Insured's Employer _____					

## Emergency Information

Name of nearest relative not living with you _____	
Complete Address _____	
Phone _____	Relationship: _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_

## Medical History

- Y N Are you under the care of a physician?  
If yes, for what? \_\_\_\_\_  
Name of physician \_\_\_\_\_
- Y N Major Surgeries or illnesses? \_\_\_\_\_
- Y N Any recent surgery or illness? \_\_\_\_\_
- Y N Are you now taking any drugs or medications?  
If yes, what? \_\_\_\_\_

## Do you now or have you ever had (Please Circle & Indicate When):

### Heart

- Y N Rheumatic fever/ scarlet fever  
Pre-Med? \_\_\_\_\_
- Y N Heart trouble/ murmur  
Pre-Med? \_\_\_\_\_
- Y N Mitral Valve Prolapse  
Pre-Med? \_\_\_\_\_
- Y N High or Low blood pressure
- Y N Heart surgery/ pacemaker  
Pre-Med? \_\_\_\_\_

### Respiratory

- Y N Chest pains
- Y N Swelling of feet/ ankles
- Y N Breathing problems
- Y N Asthma
- Y N Hay Fever
- Y N Sinusitis
- Y N Tuberculosis
- Y N Allergies/ drug interactions
- \_\_\_\_\_
- \_\_\_\_\_

### Blood

- Y N Anemia
- Y N Bleeding problems/bruise easily
- Y N Hemophilia/ blood transfusions
- Y N Jaundice/ liver problems
- Y N Hepatitis A B or C

### Other

- Y N Venereal disease
- Y N AIDS or HIV
- Y N Diabetes
- Y N Kidney/ urinary problems
- Y N Radiation/ chemotherapy
- Y N Cancer tumor
- Y N Convulsions/ seizures/ fainting
- Y N Arthritis or Rheumatism
- Y N Endocrine disturbances
- Y N Psychological/ emotional problems
- Y N Drug addictions
- Y N Frequent headaches
- Y N Glaucoma
- Y N Pregnancy or birth control pills
- Y N Stomach/ digestive problems
- Y N Special diet/ restrictions

Do you have any other disease/ condition that the Doctor should know about?

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## Dental History

- Y N Are you having any discomfort at this time? If yes, what?  
\_\_\_\_\_
- Last dental visit \_\_\_\_\_
- Y N Are any teeth sensitive to:  
Hot/ Cold/ Sweets?
- Y N Have you had oral surgery?
- Y N Have you had orthodontia?
- Y N Have you had gum infections?
- Y N Have you had perio problems?
- Y N Do you smoke?
- Y N Do you clench/ grind your teeth?
- Y N Have you ever had any occlusal treatments?
- Y N Pain in jaw joints? (popping/ clicking)
- Y N Have you ever had an unpleasant experience in a dental office?
- Y N Have you ever had an unfavorable reaction to dental treatment?
- Have you ever had an undesirable reaction to:
- Y N Local anesthetics?
- Y N Oral surgery/ extractions?
- Y N Penicillin?
- Y N Other antibiotics?
- Y N Other drugs/ medications?

**Consent**

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered truthfully and to the best of my knowledge.

I also hereby authorize the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of my (my child's) needs. I also authorize Doctor to perform any and all forms of consented treatment, medication and therapy that may be indicated in connection with said patient, and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk.

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Signature

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Date