PATIENT INFORMATION	CONFIDENTIAL
NAME ______________________________	BIRTHDATE ____________________
ADDRESS ______________________________	HOME PHONE ____________________
CITY ________________ STATE __________ ZIP __________	
PATIENT OR PARENT'S EMPLOYER ____________________	CIRCLE APPROPRIATE SELECTION:
BUSINESS ADDRESS ______________________________	MINOR SINGLE MARRIED
CITY ________________ STATE __________ ZIP __________	DIVORCED WIDOWED SEPERATED
IF PT IS A STUDENT, NAME OF SCHOOL ____________________	WORK PHONE ____________________
CITY ______________________________ STATE __________	CELL PHONE ____________________
WHOM MAY WE THANK FOR REFERRING YOU? ____________________	OTHER ____________________
______________________________	EMAIL ____________________

RESPONSIBLE PARTY	
NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ____________________	RELATIONSHIP TO PATIENT __________
______________________________	HOME PHONE ____________________
ADDRESS ______________________________	WORK PHONE ____________________
CITY ________________ STATE __________ ZIP __________	CELL PHONE ____________________
EMPLOYER ______________________________	BIRTHDATE ____________________
ADDRESS ______________________________	SS NUMBER ____________________
CITY ________________ STATE __________ ZIP __________	

INSURANCE INFORMATION	
NAME OF INSURED ______________________________	RELATIONSHIP TO PATIENT __________
INSURANCE COMPANY ______________________________	BIRTHDATE ____________________
ADDRESS ______________________________	SS NUMBER ____________________
CITY ________________ STATE __________ ZIP __________	GROUP NUMBER ____________________

PATIENT NAME ____

INSURANCE PHONE _______________

ADDITIONAL INSURANCE

NAME OF INSURED ____

RELATIONSHIP TO PATIENT _________

INSURANCE COMPANY _______________________________________

BIRTHDATE _____________________

ADDRESS ____

SS NUMBER _____________________

CITY _______________________ STATE ______________ ZIP _________

GROUP NUMBER __________________

INSURANCE PHONE _______________

PATIENT MEDICAL HISTORY

PHYSICIAN NAME ____

PHYSICIAN PHONE ________________

- ARE YOU UNDER THE CARE OF A PHYSICIAN YES NO
- HAVE YOU BEEN HOSPITALIZED IN THE LAST FIVE YEARS YES NO
- ARE YOU TAKING MEDICATIONS? INCLUDING OVER THE COUNTER AND PRESCRIPTION. YES NO
- DO YOU USE TOBACCO? YES NO
- DO YOU USE ALCOHOL? YES NO
- DO YOU USE COCAINE OR OTHER DRUGS? YES NO
- DO YOU WEAR CONTACTS? YES NO
- DO YOU HAVE ANY ALLERGIES? YES NO

  ____

  ____
- HAVE YOU EVER HAD A REACTION TO ANESTHETIC? YES NO

EXPLAIN ABOVE: ____

____

____

DATE OF LAST EXAM _______________

WOMEN ONLY:

- ARE YOU PREGNANT ________
- ARE YOU NURSING _________
- ARE YOU TAING BIRTH CONTROL PILLS ____________

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS ABOUT YOURSELF: (*MARK ALL ANSWERS WITH A YES OR NO)*

	YES	NO		YES	NO		YES	NO
HIGH BLOOD PRESSURE	___	___	FREQUENTLY TIRED	___	___	KIDNEY DISEASE	___	___
HEART ATTACK	___	___	ANEMIA	___	___	AIDS/HIV INFECTION	___	___
RHEUMATIC FEVER	___	___	EMPHYSEMA	___	___	STD'S	___	___
SWOLLEN ANKLES	___	___	CANCER	___	___	THYROID PROBLEMS	___	___
FAINING/SEIZURES	___	___	ARTHRITIS	___	___	HEPATITIS A, B OR C	___	___
ASTHMA	___	___	JOINT REPLACEMENT	___	___	ULCERS	___	___
LOW BLOOD PRESSURE	___	___	CHEST PAINS	___	___	RESPIRATORY PROBLEMS	___	___
EPILEPSY/CONVULSIONS	___	___	SHORT OF BREATH	___	___	OTHER ______________________		
LEUKEMIA	___	___	STROKE	___	___	____________________________		
DIABETES	___	___	HAY FEVER/ALLERGIES	___	___	____________________________		
HEART DISEASE	___	___	TUBERCULOSIS	___	___	____________________________		
CARDIAC PACE MAKER	___	___	RADIATION THERAPY	___	___	____________________________		

HEART MURMER ___ ___ GLAUCOMA ___ ___ ANGINA ___ ___ LIVER DISEASE ___ ___	______________________________
PATIENT NAME ____	PAGE 3

PATIENT DENTAL HISTORY

1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? ______________________________
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? ______________________________
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? ______________________________
4. DO YOU FEEL PAIN IN ANY OF YOUR TEETH? ______________________________
5. DO YOU HAVE ANY SORES OR LUMPS IN YOUR MOUTH? ______________________________
6. HAVE YOU EVER SUFFERED TRAUMA TO YOUR FACE MOUTH OR JAW? ______________________________
7. DOES YOUR JAW EVER CLICK, POP, CRACKLE OR ACHE? ______________________________
8. DO YOU HAVE PAIN IN YOUR JAW JOINT, EAR OR SIDE OF THE FACE? ______________________________
9. DO YOU HAVE DIFFICULTY OPENING OR CLOSING YOUR MOUTH? ______________________________
10. DO YOU HAVE DIFFICULTY CHEWING? ______________________________
11. DO YOU HAVE FREQUENT HEADACHES? ______________________________
12. DO YOU CLENCH OR GRIND YOUR TEETH? ______________________________
13. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? ______________________________
14. HAVE YOU HAD PROBLEMS WITH PREVIOUS DENTAL WORK? ______________________________
15. HAVE YOU EVER HAD BRACES? ______________________________
16. HOW MANY TIMES A DAY DO YOU BRUSH YOUR TEETH? ______________________________
17. HOW OFTEN DO YOU FLOSS? ______________________________
18. DO YOU USE A MANUAL BRUSH OR ELECTRIC? ______________________________
19. DO YOU USE ANY TYPE OF MOUTH RINSE? ______________________________

GOALS FOR YOUR MOUTH, TEETH AND SMILE: ______________________

____

____

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD THAT BE? ____

____

____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

____ ____________________
PATIENT SIGNATURE DATE

____
PRINT NA

____
DENTIST SIGNATURE

____
DATE

____
WITNESS SIGNATURE

____
DATE