Welcome to our Practice!

PATIENT INFORMATION ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. ❑ Child ❑ Male ❑ Female

First Name_____ M.I._____ Last Name _____ Nickname _____

Birth Date_____ Age____ Soc. Sec. # _____ E-mail: _____

Street_____ Apt. _____ City _____ State_____ Zip_____

Home # _____ Cell# _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Referred By: _____ Has a family member ever been a patient of our practice? ❑ Yes ❑ No

In case of emergency please contact - Name: _____Ph. _____
Employer Bus. Ph._____ Relationship: _____

PERSON RESPONSIBLE FOR ACCOUNT

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other Relationship: _____

Name: _____ S.S.#_____ Birth Date: _____ Age ____ Ph# _____

Street _____ Apt._____ City_____ State ____ Zip_____

Email _____ _____ Ph # _____ Employer Bus. Ph# _____

SPOUSE OR SIGNIFICANT OTHERS INFORMATION (*IF DIFFERENT THAN ABOVE*)

Name _____ Relation _____S.S.# _____Birth Date _____

Street _____ _____ Apt._____ City_____ State ____ Zip_____

Email _____ _____ Ph # _____ Employer Bus. Ph# _____

INSURANCE INFORMATION ***Please answer questions below for patient***

Student: . . . . . ❑ Full Time ❑ Part Time Marital Status: . ❑ Married ❑ Divorced ❑ Widow ❑ Single

School Name -City-State_____

Employed: . . . . .❑ Full Time ❑ Part Time ❑ Retired ❑ Not Do You have Dental Insurance? ❑ Yes ❑ No

DENTAL INSURANCE PLAN INFORMATION

Employer _____ _____ Bus. Ph # _____

Bus. Address _____

Ins. Co. Name_____ Tel.# _____

Street _____ City_____ State _____ Zip_____

Group # _____ Policy Holders Name _____ Sex: ❑ M ❑ F

ID # _____ Policy Holders ph# _____ Email _____

Date of birth of Policy Holder _____ SS # _____ Relationship to patient: _____

DENTAL INFORMATION

Reason for today's visit: Are you in pain? ❑ Yes ❑ No For How Long _____

Please indicate any of the following problems by checking off the corresponding box:

❑ Discomfort, clicking, or popping in jaw ❑ Lost / broken filling(s) ❑ Stained teeth ❑ Difficulty closing jaw

❑ Red, swollen, or bleeding gums ❑ Gum disease ❑ Locking jaw ❑ Difficulty opening jaw

❑ Do you have or use a dental appliance ❑ Ringing in ears ❑ Bad breath ❑ Loose / shifting teeth

❑ Blisters/sores in or around the mouth ❑ Burning tongue / lips ❑ Toothache ❑ Broken / chipped tooth

❑ Recent infections or sore throat ❑ Teeth grinding / clenching ❑Are you prone to cold sores

❑ Swelling / lumps in mouth ❑ Prolonged bleeding from an injury / extraction ❑ Food caught between teeth

Are your teeth are sensitive to: ❑ Hot ❑ Cold ❑ Sweets ❑ Biting

Last dental exam_____ Last dental x–rays _____Times a day you brush? ____Times a week you floss? ___

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth? ❑ Yes ❑ No

What type of toothbrush bristles do you use? ❑ Soft ❑ Medium ❑ Hard ❑ Not sure

MEDICAL INFORMATION Are you in good health? ❑ Yes ❑ No Are you under the care of a physician? ❑ Yes ❑ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ Yes ❑ No

Have you had any illness, operations, or been hospitalized in the past five years? ❑ Yes ❑ No

If yes what for: _____ When ? _____

Do you have, or have you had, any of the following diseases, medical conditions, or procedures? *Please check all that apply*

❑ High blood pressure ❑ Low blood pressure ❑ Mitral valve prolapse ❑ Heart murmur ❑Rheumatic fever

❑ Chest pain / Angina ❑ Heart attack(s) ❑ Irregular heart beat ❑ Pacemaker ❑ Heart surgery ❑ Damaged heart valve

❑ Pneumonia / Bronchitis / Chronic cough ❑ Chronic fatigue / Night sweats ❑ Trouble climbing 1-2 flights of stairs

❑ Anemia ❑ HIV / AIDS ❑ Mental health problems ❑ Problems with immune system *(possibly from med./surg.)*

❑ Delay in healing ❑ Hay fever / Sinus problems ❑ Snoring ❑ Sleep apnea / CPAP ❑ Respiratory problems

❑ Tuberculosis ❑ Emphysema ❑ Asthma ❑ Do you smoke If so, # packs a day ____ ❑ Do you use chewing tobacco

❑ A history of drug or alcohol abuse ❑A history anorexia/bulimia ❑ Abnormal bleeding ❑ Bleeding tendency

❑ Blood transfusion ❑ Blood disorder ❑ Bruise easily ❑ Eye disease /Glaucoma ❑ Jaundice /Liver disease ❑ Hepatitis

❑ Gallbladder trouble ❑ Fainting spells ❑ Convulsions / Epilepsy ❑ Stroke ❑ Thyroid trouble ❑ Diabetes

❑ Are you on dialysis ❑ Kidney trouble ❑ Contagious diseases ❑Infectious mononucleosis ❑ Low blood sugar

❑ Swollen ankles ❑ Arthritis /Joint disease ❑ Prosthetic implant ❑ Joint replacement ❑ Stomach ulcers ❑ Osteonecrosis
❑Osteoporosis /Osteopenia ❑ Tumor or growth ❑ Cancer / Radiation / Chemotherapy

MEDICATION & ALLERGIES

Are you now taking: ❑ Blood thinners (Coumadin, Plavix, Aspirin, etc...)

❑ Are you taking, or have you ever taken, any bone density meds. or bisphosphonates, such as Fosamax, Boniva, Actonel, IV Zometa, Reclast, Xgeva, Prolia, or Aredia within the past 12 years.

Are you allergic to, or had a reaction to:

❑ Penicillin ❑ Lidocaine or other anesthetic ❑ Amoxicillin ❑ Codeine or other narcotics ❑ Latex

Please list any other medication or antibiotic you are allergic to:	***Please list any allergies other than drug allergies:***

Please list any medication(s) you are taking (including natural, herbal, or homeopathic products)

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Please type below any other information you would like the Dentist to be aware of:

Questions below for women only

Women please note: *antibiotics (such as penicillin) may alter the effectiveness of birth control pills.*

Consult your physician / gynecologist for assistance regarding additional methods of birth control.

1) Is there a possibility of pregnancy? ❑ Yes ❑ No 2) Expected delivery date: _____

3) Are you nursing? ❑ Yes ❑ No 4) Are you taking birth control pills: ❑ Yes ❑ No