PATIENT INFORMATION — PLEASE PRINT

Name: ____ Home Phone: ____ Cell Phone: ____

Address: ____ City: ____ State: ____ Zip Code: ____

Birthdate: ___/___/___ Age: ____ Social Security Number: ____

Employer: ____ Work Phone Number: ____

Referred By: Patient ____ E-mail: ____
(please specify)
❑ TV ❑ Website ❑ Yahoo ❑ Yellow Pages ❑ YELP ❑ Doctor ❑ Radio ❑ Other

SPOUSE/RESPONSIBLE PARTY INFORMATION

Spouse / Parents Name: ____ Home Phone: ____ Cell Phone: ____

Birthdate: ___/___/___ Age: ____ Social Security Number: ____ Relationship to Patient: ____

❑ Same as above
Address: ____ City: ____ State: ____ Zip Code: ____

Employer: ____ Work Phone Number: ____

Employer Address: ____

Relationship to Insured: ____ Occupation: ____

PRIMARY DENTAL INSURANCE

❑ YES ❑ NO (Please Provide Card) PCP Name ____ Phone: ____

DENTAL HISTORY

How long since you have seen a dentist? ____

Are you currently in pain? ____

Are you apprehensive about dental treatment? ____

Do your gums bleed, or feel tender, or irritated? ____

Are your teeth sensitive to hot, cold, sweets, or pressure? ____

Are you aware of clenching or grinding your teeth? ____

Do you have headaches, earaches, or neck pain? ____

Do you regularly use dental floss? ____

How often do you brush? ____

Current patient? Y N

If YES, approx last apt. ____

If NO, why did you leave your last dentist? ____

Are you seeking dentistry with anesthesia? Y N

Have you had anesthesia in the past? Y (Date ___/___/___) N

Have you ever had teeth removed? Y N

How long have those teeth been missing? ____

Do you feel you will eventually wear dentures? ____

What medications are you currently taking? ____

____

Do you take prescription or OTC antacids? Y N

Please list any medications or substances you may be ALLERGIC to:

____

____

MEDICAL HISTORY

Do you currently have any health problems? Y N
If YES, for what? ____

Are you currently under physician's care? Y N
If YES, for what? ____

Are you currently Pregnant or Nursing? Y N

Cardiac Abnormalities? ❑ None (CHD, HM, MVP, Other____)

Check any of the following which you have had, or presently have:

❑ AIDS/HIV+	❑ Drugs/Alcohol Abuse	❑ Jaw Locking/Catching
❑ Allergies (Seasonal ❑)	❑ Earaches	❑ Jaw Muscles Tired
❑ Anemia	❑ Emphysema	❑ Liver Disease
❑ Anesthetic Reaction describe:	❑ Epilepsy/Seizures	❑ Mitral Valve Prolapse Premed ____
❑ Angina Pectoris	❑ Fever Blisters	❑ Neck Pain
❑ Arthritis (RA or OA)	❑ Glaucoma	❑ Nervousness
❑ Artificial Heart Valve Blood thinner? Y N	❑ Hay Fever	❑ Psychiatric Treatment
❑ Asthma	❑ Headaches/Facial Pain	❑ Radiation Treatment
❑ Blood Transfusion	❑ Heart Disease/Attack	❑ Recreation Drug Use
❑ Bruise Easily	❑ Heart Murmur Premed ____	❑ Rheumatic Fever
❑ Change in Bite	❑ Heart Pacemaker	❑ Ringing in Ears
❑ Clenching/Grinding	❑ Heart Surgery	❑ Sinusitis
❑ Chemotherapy	❑ Hemophilia	❑ Smoker
❑ Congenital Heart Defect	❑ Hepatitis, Type( )	❑ Stroke
❑ Cortisone Medications	❑ High Blood Pressure	❑ Tuberculosis
❑ Diabetes	❑ Jaw Joint Pain	❑ Ulcer
❑ Dizziness/Loss of Balance	❑ Jaw Clicking/Popping	❑ Venereal Disease

❑ Artificial Joint : Type____ Premed____

Signature: ____ Date: ____