

Date _____

Confidential Patient Information

A B C

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

Confidential Responsible Party Information

Name _____ Marital Status _____
Last First Middle
 Residence _____ Own Rent
Street City State Zip
 Mailing Address _____ Email _____
Street City State Zip
 How long at this address _____ Previous Address _____
(if less than 3 yrs) Street City State Zip
 Home Phone _____ Work Phone _____ Cell Phone _____
 Social Security # _____ Birthdate _____ Relationship to Patient _____
 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

Policy Holder's Name _____ and Soc. Sec. # _____
 Insurance Company _____ Group No. _____ Union Local No. _____
 Insurance Co. Address _____ Insurance Co. Phone _____
 Policy Holder's Employer _____
 Do you have dual coverage? No Yes If yes:
 Policy Holder's Name _____ and Soc. Sec. # _____
 Insurance Company _____ Group No. _____ Union Local No. _____
 Insurance Co. Address _____ Insurance Co. Phone _____
 Policy Holder'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) _____

Physician's Name: _____

Phone: _____

General Dentist's Name: _____

Phone: _____

Are you currently under any medical treatment? Please list	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently taking any medication? Please list the medication	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have allergies? (Sulphur, Penicillin, Novocaine, etc.) Please list	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a latex allergy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a nickel allergy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever taken bisphosphonates, etc. for Osteoporosis (i.e. Fosamax)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a heart condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you pre-medicate prior to dental visits?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have sleep apnea?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you bleed easily?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there a tendency to faint or become dizzy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you smoke or chew tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have pain, clicking, and/or popping noises in your jaw?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you aware of either clenching or grinding of teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have frequent headaches? If so, how frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have ear problems? (Aches, ringing, dizziness, fullness)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have difficulty breathing through the nose?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have habits such as nail biting, finger or thumb sucking, lip or cheek biting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you aware of any speech problems, or are you in speech therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had your tonsils and/or adenoids removed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been informed of any extra or missing teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have there been any injuries to the teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any permanent teeth extracted?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have we treated any other family members? Name(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Has there been any history of any of the following:

- Joint Swelling
 Asthma
 TB
 Aids
 Kidney Disorder
 Liver Condition
 Epilepsy
 Rheumatic Fever
 Other major illnesses: _____

In your own words what is your chief concern? _____

Which of the following categories is **most** important to you (PLEASE MARK ONE)?

- Quality
 Cost
 Comfort
 Time

 Patient Signature

 Date

 Parent Signature

OTHER INFORMATION: Siblings and/or children under age 18

	Sibling/Child Name:	Birth Date:
1.		
2.		
3.		
4.		

FOR OFFICE USE ONLY

