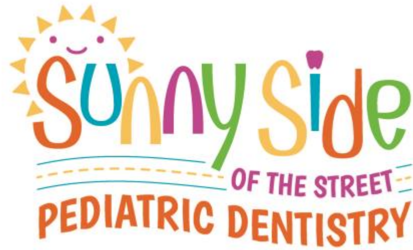

NAME ____

ADDRESS ____

CITY __________________________ STATE ___________ ZIP ___________

CELL-PHONE ______________________________ E-MAIL ______________

PATIENT OR PARENT'S EMPLOYER __________________________________

BUSINESS ADDRESS _______________________________________

CITY _________________________ STATE ____________ ZIP ____________

WHOM MAY WE THANK FOR REFERRING YOU? _______________________

____

BIRTHDATE

____

HOME PHONE

____

CIRCLE APPROPRIATE SELECTION:

MINOR SINGLE MARRIED

DIVORCED WIDOWED SEPERATED

WORK PHONE

____

____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT __________________

____

ADDRESS ____

CITY _________________________ STATE _____________ ZIP ___________

EMPLOYER ____

ADDRESS ____

CITY _________________________ STATE _____________ ZIP ___________

RELATIONSHIP TO PATIENT

____

HOME PHONE

____

WORK PHONE

____

CELL PHONE

____

BIRTHDATE

____

SS NUMBER

____

INSURANCE INFORMATION

NAME OF INSURED ____ INSURANCE COMPANY ____ ADDRESS ____ CITY _________________________ STATE _______________ ZIP __________ PATIENT NAME ____	RELATIONSHIP TO PATIENT ______________________ BIRTHDATE ______________________ SS NUMBER ______________________ GROUP NUMBER __________________ INSURANCE PHONE _______________

ADDITIONAL INSURANCE

NAME OF INSURED ____ INSURANCE COMPANY ____ ADDRESS ____ CITY _________________________ STATE _______________ ZIP __________	RELATIONSHIP TO PATIENT _________ BIRTHDATE ______________________ SS NUMBER ______________________ GROUP NUMBER __________________ INSURANCE PHONE _______________

PATIENT MEDICAL HISTORY

PHYSICIAN NAME ____ ARE YOU UNDER THE CARE OF A PHYSICIAN YES NO HAVE YOU BEEN HOSPITALIZED OR HAD SURGERIES IN THE LAST SIX YEARS? YES NO ARE YOU TAKING MEDICATIONS? INCLUDING OVER THE COUNTER AND PRESCRIPTION. YES NO PLEASE LIST: (IF NOT ENOUGH SPACE, ATTACH SEPARATE DOCUMENT) ____ ____ ____ DO YOU USE TOBACCO? YES NO DO YOU USE ALCOHOL? YES NO DO YOU USE RECREATIONAL DRUGS? YES NO DO YOU WEAR CONTACTS? YES NO DO YOU HAVE ANY ALLERGIES? YES NO	PHYSICIAN PHONE ________________ DATE OF LAST EXAM _______________ WOMEN ONLY: ARE YOU PREGNANT YES NO ARE YOU NURSING YES NO ARE YOU TAKING BIRTH CONTROL PILLS YES NO

____
____

HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL, OR ANY OTHER MEDICATIONS CONTAINING BISPHOSPHONATES? YES NO

HAVE YOU EVER HAD A REACTION TO ANESTHETIC? YES NO

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

ASPIRIN YES NO PENICILLIN YES NO CODEINE YES NO
ACRYLIC. YES NO METAL YES NO LATEX YES NO
SULFA DRUGS YES NO

OTHER ALLERGIES: ____
____
____

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	___	___			
RHEUMATIC FEVER	___	___	EMPHYSEMA	___	___	AIDS/HIV INFECTION	___	___
SWOLLEN ANKLES	___	___	CANCER	___	___			
FAINING/SEIZURES	___	___	ARTHRITIS	___	___	STD'S	___	___
ASTHMA	___	___	JOINT REPLACEMENT	___	___			
LOW BLOOD PRESSURE	___	___	CHEST PAINS	___	___	THYROID PROBLEMS	___	___
EPILEPSY/CONVULSIONS	___	___	SHORT OF BREATH	___	___			
LEUKEMIA	___	___	STROKE	___	___	HEPATITIS A, B OR C	___	___
DIABETES	___	___	HAY FEVER/ALLERGIES	___	___			
HEART DISEASE	___	___	TUBERCULOSIS	___	___	ULCERS	___	___
CARDIAC PACE MAKER	___	___	RADIATION THERAPY	___	___			
HEART MURMER	___	___	GLAUCOMA	___	___	RESPIRATORY PROBLEMS	___	
ANGINA	___	___	LIVER DISEASE	___	___			

OTHER:
____
____
____
____
____
____
____
____
____

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 NAME

____
DENTIST SIGNATURE

____
DATE

____
WITNESS SIGNATURE

____
______
DATE