Patient Information

Date-__________

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently. Incorrect information can be dangerous to your health.

Patient's Last Name	First Name	MI	Date of Birth	Marital Status
Current Address	City	State	Zip	Home Phone
Your Employer		Occupation		Years With Firm
Employers Address	City	State	Zip	Business Phone
Social Security Number	Driver's License Number	E-mail Address		Cell Phone
Nearest Relative Not Living With You	Address			Phone

Dental Insurance - Primary Coverage

Name of Dental Insurance Company		
Address		
Telephone		
Subscriber's Name (employee) Relationship to Patient		
Subscriber's Social Security Number		
Subscriber's Date of Birth		
Name of Group Policy Holder /Employer's Name		
Group Policy Number Individual Policy Number		

Medical History

Name of Physician	Phone
Address	Date of Last Physical

1. Are you currently under the care of a physician? If yes, for what condition?________________________________

2. Are you currently taking any medications? If yes, what medications and for what reason or condition?______________

Have you ever had or been treated for:	**YES**	**NO**	**DOCTOR'S COMMENTS**
3. Rheumatic fever, rheumatic heart disease, heart murmur, or congenital heart disease?	☐	☐	
4. Heart trouble, heart attack, angina, heart surgery, pacemaker or irregular beat?...	☐	☐	
5. Stomach or intestinal disease?..	☐	☐	
6. Abnormal blood pressure, excessive bleeding or anemia?...........	☐	☐	
7. Breathing problems, asthma, tuberculosis or hay fever?.................	☐	☐	

(Continued on reverse side)

Medical History	YES	NO	DOCTORS COMMENTS
8. Cancer, radiation treatments or chemotherapy?	☐	☐	
9. Diabetes?	☐	☐	
10. Hepatitis, jaundice or liver disease?	☐	☐	
11. Kidney problem or renal dialysis?	☐	☐	
12. Venereal disease or AIDS?	☐	☐	
13. A stroke, convulsions or fainting spells?	☐	☐	
14. Tumors or growths?	☐	☐	
15. Arthritis or rheumatism?	☐	☐	
16. Allergic reactions to medications?	☐	☐	
17. Have you ever had a major operation?	☐	☐	
18. Have you ever had a serious injury to your head or neck?	☐	☐	
19. Are you on a special diet?	☐	☐	
20. Women: Are you pregnant?	☐	☐	
21. Are there any problems about your health of which you are aware?	☐	☐	
22. Tattoos, body piercing: ears ,tongue, nose, other?	☐	☐	
23. Prosthetics/Implants: Hips, joints, breast, other?	☐	☐	

DENTAL HISTORY

Reason for today's visit: ______________________________

Date of last dental visit: ______________ Reason for last visit: ______________

Would you like us to transfer records? ______________ From what office? ______________

Do you have any of your x-rays or dental records? ______________

In respect to any previous dental treatment, have you:	YES	NO	DOCTORS COMMENTS
24. Ever fainted?	☐	☐	
25. Had an allergic reaction?	☐	☐	
26. Had abnormal bleeding?	☐	☐	
27. Had any other complications during or following treatment?	☐	☐	
28. Do your gums bleed on brushing or eating?	☐	☐	
29. Does food catch between your teeth?	☐	☐	
30. Have your teeth shifted, flared or became loose?	☐	☐	
31. Are any of your teeth sensitive to heat, cold or pressure?	☐	☐	
32. Do you grind your teeth or clench your jaws?	☐	☐	
33. Do you have pain or clicking in the jaw joint around your ears?	☐	☐	
34. Are there any sores or growths in your mouth?	☐	☐	
35. Do any of your teeth ache?	☐	☐	
36. Do you have any other dental complaints?	☐	☐	
37. Do you prefer nitrous oxide ("laughing gas") during dental treatment?	☐	☐	

NOTE: A change in health status should be reported to the office at the earliest possible time.

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize the release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advise and treatment to another dentist.

I understand that I am responsible for all cost of dental treatment.

I hereby authorize payment of insurance benefits to the dentist or dental group, otherwise payable to me.

I attest to the accuracy of the information on this questionnaire.

Patient or Parent Signature ______________________________ - Date ______________

Print Your Name ______________________________

If other than patient, indicate relationship ______________________________

How did you hear about us? ______________________________

Reviewed by ______________