

(PLEASE FILL OUT COMPLETELY)

**1) PATIENT INFORMATION**

Child  Single  Married  Divorced  Widowed

**Today's Date:**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**First Name:** \_\_\_\_\_ **MI:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_\_  Male  Female **Social Security #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Address:**

\_\_\_\_\_

\_\_\_\_\_

**City:** \_\_\_\_\_ **State:**

**Zip:** \_\_\_\_\_

**Full Time Student:**  Yes  No **School Name:**

\_\_\_\_\_

**Who may we thank for referring you:**

\_\_\_\_\_

**2) TELEPHONE & EMAIL**

**Home #:** (\_\_\_\_) \_\_\_\_\_ **Work #:** (\_\_\_\_) \_\_\_\_\_

**Cell #:** (\_\_\_\_) \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Would you like to receive reminders via:** **Email?**  Yes  No **Text Messages?**  Yes  No

**In the event of an emergency, who should we contact?**

**Name:** \_\_\_\_\_ **Relationship:**

\_\_\_\_\_

**Home Phone:**(\_\_\_\_) \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_

**Cell Phone:** (\_\_\_\_) \_\_\_\_\_

**3) RESPONSIBLE PARTY (Parent/Guardian)**

**Name of Person Responsible for this account:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_\_ **Drivers License #:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_  
**Zip:** \_\_\_\_\_

**Home Phone:**(\_\_\_\_) \_\_\_\_\_ **Work Phone:**(\_\_\_\_) \_\_\_\_\_  
**Cell Phone:**(\_\_\_\_) \_\_\_\_\_

#### 4) INSURANCE INFORMATION

Dental Coverage  Yes  No

**Name of Insurance Co:** \_\_\_\_\_ **Insurance Co.**  
**Phone:**(\_\_\_\_) \_\_\_\_\_

**Name of Insured:** \_\_\_\_\_  
**Relation:** \_\_\_\_\_

**ID# or SSN:** \_\_\_\_\_ **Birth**  
**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Employer:** \_\_\_\_\_ **Insurance Group #:** \_\_\_\_\_

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**Patients Name:** \_\_\_\_\_

#### 5) DENTAL HISTORY

Reason for Today's Visit:  
\_\_\_\_\_  
\_\_\_\_\_

Do you require antibiotics before dental treatment?

.....  
.. Yes\_\_\_ No\_\_\_

Are you currently in pain?

..... Yes \_\_\_ No \_\_\_

Do your gums ever bleed?

..... Yes \_\_\_ No \_\_\_

Have you ever had difficulties associated with any previous dental work?

..... Yes \_\_\_ No \_\_\_

Do you or have you ever experienced pain in your jaw joint (TMJ / TMD)?

..... Yes \_\_\_ No \_\_\_

When was your last dental exam?

\_\_\_\_\_

When was the last time you had dental x-rays taken?

\_\_\_\_\_

When was your last teeth cleaning?

\_\_\_\_\_

**6) MEDICAL HISTORY**

**Current Physician:** \_\_\_\_\_ **Current Physician**  
**Phone:(\_\_\_\_\_)** \_\_\_\_\_

Do you consider yourself in good medical health?.....

..... Yes \_\_\_ No \_\_\_

Are you taking any medications?.....

..... Yes \_\_\_ No \_\_\_

If so, please list:\_\_\_\_\_

\_\_\_\_\_

Are you allergic to any of the following?

Codeine ..... Yes \_\_\_ No \_\_\_

Dental anesthetics ..... Yes \_\_\_ No \_\_\_

Erythromycin ..... Yes \_\_\_ No \_\_\_

Latex or rubber products..... Yes \_\_\_ No \_\_\_

Metals ..... Yes \_\_\_ No \_\_\_

Penicillin ..... Yes \_\_\_ No \_\_\_

Tetracycline ..... Yes \_\_\_ No \_\_\_

Other..... Yes \_\_\_ No \_\_\_

**FOR WOMEN:** Are you currently pregnant? Yes \_\_\_ No \_\_\_ If so, how many weeks?  
\_\_\_\_\_ Are you nursing? Yes \_\_\_ No \_\_\_

How many children have you had? \_\_\_\_\_ Are you taking  
birth control? Yes \_\_\_ No \_\_\_

**Do you have or have you ever had any of the following diseases, medical conditions,  
or procedures?**

Abnormal bleeding Yes \_\_\_ No \_\_\_

Alcohol/Drug abuse Yes \_\_\_ No \_\_\_

Anemia Yes \_\_\_ No \_\_\_

Arthritis Yes \_\_\_ No \_\_\_

Asthma Yes \_\_\_ No \_\_\_

Cancer/Tumors Yes \_\_\_ No \_\_\_

Chest Pains Yes \_\_\_ No \_\_\_

Diabetes Yes \_\_\_ No \_\_\_

Difficulty Breathing Yes \_\_\_ No \_\_\_

Emphysema Yes \_\_\_ No \_\_\_

Epilepsy Yes \_\_\_ No \_\_\_

Fainting/Seizure Yes \_\_\_ No \_\_\_

Frequent Headaches Yes\_\_\_ No\_\_\_

Glaucoma Yes\_\_\_ No\_\_\_

Hay Fever Yes\_\_\_ No\_\_\_

Heart Attack/Stroke Yes\_\_\_ No\_\_\_

Heart Murmur Yes\_\_\_ No\_\_\_

Heart Surgery Yes\_\_\_ No\_\_\_

High Blood Pressure Yes\_\_\_ No\_\_\_

Hepatitis Yes\_\_\_ No\_\_\_

Herpes/Fever Blister Yes\_\_\_ No\_\_\_

HI/AIDS Yes\_\_\_ No\_\_\_

Kidney Problems Yes\_\_\_ No\_\_\_

Liver Problems Yes\_\_\_ No\_\_\_

Mitral Valve Prolapse Yes\_\_\_ No\_\_\_

Pacemaker Yes\_\_\_ No\_\_\_

Rheumatic Fever Yes\_\_\_ No\_\_\_

Respiratory Problems Yes\_\_\_ No\_\_\_

Shingles Yes\_\_\_ No\_\_\_

Sickle Cell Disease Yes\_\_\_ No\_\_\_

Sinus Problems Yes\_\_\_ No\_\_\_

Shortness in Breath Yes\_\_\_ No\_\_\_

Thyroid Problems Yes\_\_\_ No\_\_\_

Tuberculosis TB Yes\_\_\_ No\_\_\_

Ulcers Yes\_\_\_ No\_\_\_

Venereal Disease Yes \_\_\_ No \_\_\_

**7) ACKNOWLEDGEMENT & AUTHORIZATION**

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_