PATIENT INFORMATION FORM

Please complete all information. Use N/A when filling out information if it does not apply

Patient Name:_____ Date_____

Address _____

City _____ State_____ Zip Code_____

DOB:_____

Phone: Home _____ Work_____ Cell_____

SSN:_____ Driver's License #_____

Email _____

Employer_____ Occupation_____

Single_____ Married_____ Widowed_____ Divorced_____

Purpose of Visit_____

Whom may we thank for referring you to our office _____

How did you hear about us _____

Name of Dental Insurance_____

Policy Holder: Self_____ Spouse_____ Other_____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship to Patient_____

Address _____

City _____ State_____ Zip Code_____

Phone: Home _____ Work_____ Cell_____

SPOUSE/LEGAL GUARDIAN INFORMATION

Name _____ Relationship to Patient_____

Address _____

City _____ State_____ Zip Code_____

Phone: Home _____ Work_____ Cell_____

SSN:_____ Driver's License #_____

Verified Insurance will be accepted as partial payment for dental treatment. Patient share is expected at the time services are rendered. Please check Method of Payment:

Cash_____ Check_____ Credit Card_____

MEDICAL HISTORY

Certain illnesses and drugs may make it necessary to alter your treatment. In order to provide you with the best oral health care, it is necessary to have the following information. Have you ever had or currently have the following. If yes, please indicate "yes" and circle the illness.

	Yes	No
Asthma, Hay Fever, sinusitis or other allergies	☐	☐
Allergy to Penicillin, Aspirin, Local or General Anesthetic or other drugs. Specify:	☐	☐
Blood pressure or heart problems	☐	☐
Rheumatic fever. Heart murmur. Mitral Valve Prolapse	☐	☐
A pacemaker. Open heart surgery. Heart valve replacement	☐	☐
Diabetes, Liver, Kidney, Thyroid or Lung problems	☐	☐
Ulcer or Stomach problems	☐	☐
Hepatitis or Jaundice	☐	☐
Epilepsy or Nervous Disorders	☐	☐
Bleeding or Clotting Disorders	☐	☐
Arthritis, Hip Replacement Surgery or Prosthetic Joint Replacement	☐	☐
Communicable diseases: Tuberculosis. Herpes. Venereal Diseases	☐	☐
Acquired Immune Deficiency Syndrome (AIDS). HIV Positive. A.R.O.	☐	☐
Any other illnesses. Please Specify:	☐	☐
Do your wounds heal slowly or present complications?	☐	☐
Are you presently taking any medication? Specify:	☐	☐
Are you presently under the care of a physician?	☐	☐
Have you ever been hospitalized? Date: Reason:	☐	☐
Have you had or are currently undergoing Chemotherapy?	☐	☐
Are you presently on a diet?	☐	☐
When was your last physical exam? Date:		
Women: Are you taking birth control pills? Yes☐ No☐ Are you pregnant? Yes ☐ No☐		

DENTAL HISTORY

Date of last Dental Exam:	Date of Last Full Mouth X-ray:	Where was it taken:

Is there anything about your smile you would like to change?	☐	☐
Have you had trouble from previous dental care?	☐	☐
Do you have pain in your jaw or near your ears?	☐	☐
Do you have any unhealed injuries or inflamed areas in or around your mouth?	☐	☐
Have you experienced any growths or sore spots in your mouth?	☐	☐
Does any part of your mouth hurt when clenched?	☐	☐
Have you ever had Novocain or other local anesthetic?	☐	☐
Have you ever had nitrous oxide (laughing gas)?	☐	☐
Have you ever had general anesthesia?	☐	☐
Have you ever had any reaction or allergic symptoms to Novocain, local or general anesthetic?	☐	☐
Have you ever had any difficult extractions in the past?	☐	☐
Have you ever had prolonged bleeding following extractions in the past?	☐	☐
Do your gums bleed?	☐	☐
Do you have a bad taste in your mouth or mouth odor?	☐	☐
Have you ever had instructions on the care of your gums?	☐	☐
Do you chew on only one side of your mouth? If so, why?	☐	☐
Do you habitually clench or grind your teeth during the day or night?	☐	☐
Is any part of your mouth sensitive to pressure or irritants (hot or cold water, sweets)	☐	☐

Patient Signature_____ Date_____