



Today's Date: _____

Patient Information:

Last Name: _____ First: _____ Middle: _____ Driver's License #: _____
 Address: _____ City: _____ State: _____ Zip code: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 Birth date: _____ Social Security #: _____ Email Address: _____

Person Responsible for Payment:

Last Name: _____ First: _____ Middle: _____ Relationship to Patient: _____
 Address: _____ City: _____ State: _____ Zip code: _____
 Social Security #: _____
 Birth date: _____
 Driver's License #: _____
 Home Phone: _____
 Employer: _____
 Work Phone: _____

If Minor, list parent's first and last names:

Mother: _____
 Father: _____

Patient's Spouse Information:

Full Name: _____
 Employer: _____
 Occupation: _____
 Work Phone: _____

Dental Insurance Information: (we'll need a copy of your card)

Insured's Name (employee): _____
 Insured's Birth date: _____
 Insured's Address: (if different from above) _____
 Insured's Social Security #: _____
 Insured's Employer: _____
 Insurance Company Name: _____ Group Name: _____
 Insurance Company Address: _____

Emergency Information:

Local Friend or Relative not living with you: _____
 Complete Address: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____

Getting to Know You:

Why did you select our office? _____
 Whom may we thank for referring you? _____
 Is another member of your family a patient in our practice? _____
 When was your last dental visit? _____
 When was the last time you had complete dental X-rays taken? _____ Dentist Name: _____

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistant as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

Signature of Responsible Party: _____ Relationship: _____ Date: _____



Have you been under the care of a medical doctor during the past two years? _____ YES NO

If yes, for what reason? _____

Please provide the name, address and phone number for your physician _____

Are you having dental problems at this time? _____ YES NO

Do your gums bleed at any time? _____ YES NO

Do you feel very nervous about having dental treatment? _____ YES NO

Have you ever had a bad experience in the dental office? _____ YES NO

Have you been a patient in the hospital during the past two years? _____ YES NO

If yes, please describe: _____

Have you taken any medicine or drugs during the past two years? _____ YES NO

Are you allergic to or made sick by penicillin, aspirin, codeine, or any drugs or medications? _____ YES NO

If yes, please list: _____

Have you ever been told to pre-medicate before dental visits? _____ YES NO

Have you ever had excessive bleeding requiring special treatment? _____ YES NO

Check any of the following which you have had or have at the present:

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> HIV Positive (AIDS) |
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis A (Infectious) |
| <input type="checkbox"/> Angina Pectoris (chest pain) | <input type="checkbox"/> Hepatitis B (Serum) | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Heart Murmur/Mitral Valve |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Congenital Heart lesions | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Venereal Disease (Syphilis, Gonorrhea) |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> X-Ray or Cobalt Treatment | <input type="checkbox"/> Cold Sores or Fever Blisters |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Chemotherapy (Cancer, Leukemia) | <input type="checkbox"/> Genital Herpes |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Fainting or Dizzy Spells |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric Treatment |
| | | <input type="checkbox"/> Sickle Cell Disease |

Please list all medications you are taking at this time: _____

Are you a smoker? _____ YES NO

Do you use or have you ever used recreational drugs? _____ YES NO

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath or because you are very tired? _____ YES NO

Do your ankles swell during the day? _____ YES NO

Have you lost or gained more than 10 pounds in the last year? _____ YES NO

Do you ever wake up from sleep short of breath? _____ YES NO

Are you on a special diet? _____ YES NO

Do you have any disease, condition or problem listed above? _____ YES NO

If yes, please list/describe: _____

How do you feel about getting and maintaining a healthy mouth? _____

How do you feel about the appearance of your teeth? _____

If you could change anything about your smile, what would you change? _____

For Women: Are you pregnant? YES NO If yes, what month are you due? _____

Are you taking birth control pills? _____

Signature: _____

Date: _____