



Personal Information

Name _____
I prefer to be called _____
Single _____ Married _____
Male _____ Female _____
Birth date _____
Social security # _____
Home address _____

Home phone _____
Work phone _____
Cell phone _____
Email address _____
How do you prefer to be confirmed?
Home phone Cell phone Email

Other family members seen by us _____
Referred by _____

Person responsible for account _____
Relationship _____
Social security # _____
Home phone _____
Work phone _____
Billing address _____

Are you currently under the care of a physician? _____
Physician's name _____
Physician's phone # _____
Are you currently taking any prescription or over the counter drugs? Please list _____
Do you smoke or use tobacco in any form? Yes _____ No _____

For women only: Are you pregnant? _____ Nursing _____
Are you taking birth control pills? Yes _____ No _____

Insurance Information

Primary:
Dental coverage: Yes _____ No _____
Insurance Co. name _____
Insurance Co. address _____
Insurance Co. phone # _____
Group # _____
Insured's name _____
Relationship _____
Insured's date of birth _____
Insured's social security # _____
Insured's employer _____

Secondary:
Dental coverage: Yes _____ No _____
Insurance Co. name _____
Insurance Co. address _____
Insurance Co. phone # _____
Group # _____
Insured's name _____
Relationship _____
Insured's date of birth _____
Insured's social security # _____
Insured's employer _____

- Dental History -

Previous dentist _____ Last date of checkup or cleaning _____

Do you require antibiotics before dental treatment? Yes _____ No _____

Do you have discomfort in your jaw joint? (TMJ / TMD) Yes _____ No _____

Do your gums ever bleed? Yes _____ No _____

Why have you come to the dentist today? _____

Are you happy with your smile? _____

Please circle the most important feature(s) in your smile that you would like to change.

Color Shape Alignment Length Gaps Gum display Other _____

Have you ever had any of the following diseases or medical problems?

Yes No Abnormal Bleeding

Yes No Alcohol / Drug abuse

Yes No Anemia

Yes No Arthritis

Yes No Artificial joints

Yes No Artificial heart valve

Yes No Asthma

Yes No Blood transfusion

Yes No Cancer / Chemotherapy

Yes No Colitis

Yes No Congenital Heart Defect

Yes No Diabetes

Yes No Difficulty breathing

Yes No Emphysema

Yes No Epilepsy

Yes No Fainting spells

Yes No Frequent headaches

Yes No Glaucoma

Yes No Hay Fever

Yes No Heart Murmur

Yes No Heart Attack

Yes No Heart Surgery

Yes No Hemophilia

Yes No Hepatitis A, B, C

Yes No Herpes / Fever blisters

Yes No High Blood pressure

Yes No HIV+ / AIDS

Yes No Kidney problems

Yes No Liver disease

Yes No Low blood pressure

Yes No Mitral valve prolapse

Yes No Pacemaker

Yes No Psychiatric problems

Yes No Radiation treatment

Yes No Rheumatic / Scarlet fever

Yes No Seizures

Yes No Shingles

Yes No Sickle cell disease / traits

Yes No Sinus problems

Yes No Stroke

Yes No Thyroid problem

Yes No Tuberculosis (TB)

Yes No Ulcers

Yes No Venereal disease

Have you been hospitalized for any reason? _____

Please list any other serious medical conditions that you have ever had.

Are you allergic to any of the following?

Yes No Aspirin Yes No Erythromycin Yes No Metals

Yes No Codeine Yes No Jewelry Yes No Penicillin

Yes No Dental anesthetics Yes No Latex Yes No Tetracycline

Please list any other drugs/ materials that you might be allergic to.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____

Print name _____

Date _____