## PATIENT INFORMATION

Date _____

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

E-Mail Address _____ Home Phone _____ Cell Phone _____

Check Appropriate Box ___ Minor ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Name of person responsible for account _____

**IN CASE OF EMERGENCY, CONTACT** *(someone who does not live in your household)*

Name _____ Relationship _____

Home Phone _____ Work Phone _____

## INSURANCE INFORMATION

Name of Insured _____ Relationship to patient _____

Birthdate _____ SS# / Subscriber# _____

Name of Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Phone # _____

**DO YOU HAVE AN ADDITIONAL INSURANCE? ___YES ___NO IF YES, COMPLETE THE FOLLOWING:**

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# / Subscriber# _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group # _____ Phone # _____

## DENTAL HISTORY

| | Y | N |
|---|---|---|
| 1. Do your gums bleed while brushing or flossing? | ___ | ___ |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | ___ | ___ |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | ___ | ___ |
| 4. Do you feel pain in any of your teeth? | ___ | ___ |
| 5. Do you have any sores or lumps in or near your mouth? | ___ | ___ |
| 6. Have you ever experienced any of the following problems in your jaw? | | |
| a. Clicking? | ___ | ___ |
| b. Pain (joint, ear, side of face)? | ___ | ___ |
| c. Difficulty in opening or closing? | ___ | ___ |
| d. Difficulty in chewing? | ___ | ___ |
| 7. Do you have frequent headaches? | ___ | ___ |
| 8. Do you clench or grind your teeth? | ___ | ___ |
| 9. Do you bite your lips or cheeks frequently? | ___ | ___ |
| 10. Have you had any orthodontic treatment? | ___ | ___ |
| 11. Have you had any head, neck or jaw injuries? | ___ | ___ |

## MEDICAL HISTORY

| | Y | N |
|---|---|---|
| 1. Are you under a physician's care now? | ___ | ___ |
| 2. Have you ever been hospitalized for any surgeries or serious illness? | ___ | ___ |
| If yes, was there placement of pins, valves or artificial joints? Please explain _____ | | |
| 3. Are you currently taking any medications? | ___ | ___ |
| If yes, please list _____ | | |
| 4. Do you use tobacco? | ___ | ___ |
| 5. Are you pregnant? | ___ | ___ |

6. Are you allergic to or have you had any reactions to the following?

___Local Anesthetics ___Penicillin or any other Antibiotics

___Sulfa Drugs ___Iodine ___Aspirin ___Latex Rubber

___Codeine ___Barbiturates ___Metals ___Other_____

Do you have or have you had any of the following?

| | Y | N | | Y | N | | Y | N |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | ___ | ___ | Heart Disease | ___ | ___ | Heart Attack | ___ | ___ |
| Cardiac Pacemaker | ___ | ___ | Rheumatic Fever | ___ | ___ | Heart Murmur | ___ | ___ |
| Stroke | ___ | ___ | Angina | ___ | ___ | Hay Fever/Allergies | ___ | ___ |
| Fainting/Seizures | ___ | ___ | Emphysema | ___ | ___ | Tuberculosis | ___ | ___ |
| Asthma | ___ | ___ | Cancer | ___ | ___ | Radiation Therapy | ___ | ___ |
| Low Blood Pressure | ___ | ___ | Anemia | ___ | ___ | Glaucoma | ___ | ___ |
| Epilepsy | ___ | ___ | Leukemia | ___ | ___ | Arthritis | ___ | ___ |
| Liver Disease | ___ | ___ | Diabetes | ___ | ___ | Joint Replacement or Implant | ___ | ___ |
| Thyroid Problem | ___ | ___ | Kidney Diseases | ___ | ___ | Hepatitis / Jaundice | ___ | ___ |
| Respiratory Problems | ___ | ___ | AIDS or HIV Infection | ___ | ___ | Mitro Valve Prolapse | ___ | ___ |

*This is to certify that the information given above is true and correct to the best of my knowledge.*

_____

**SIGNATURE OF PATIENT or PARENT/GUARDIAN, if minor**