PATIENT INFORMATION (please print)

Name_____ **Home Phone#**_____ **Cell Phone #**_____
Address_____ **City**_____ **State**_____ **Zipcode**_____
Bithdate_____ **Age**_____ **Social Security #**_____ **Marital Status: S / M / W / D**
Employer_____ **Work Phone#**_____
Employer Address_____ **Occupation**_____
If Full Time Student, School Name and Address_____
Email Address _____
Referred By: Doctor_____ **Patient**_____ **Other**_____

SPOUSE / PARENT RESPONSIBLE PARTY

Spouse/Parents Name_____ **Home Phone #**_____ **Cell Phone #**_____
Address_____ **City**_____ **State**_____ **Zipcode**_____
Bithdate_____ **Age**_____ **Social Security #**_____ **Relation to Patient**_____
Employer_____ **Work Phone#**_____
Employer Address_____ **Occupation**_____

Primary Dental Insurance

Insured's Name_____
Insurance Co._____
Insurance Address_____
Insurance Phone # _____
Group # _____ **Local #**_____

Secondary Dental Insurance

Insured's Name_____
Insurance Co._____
Insurance Address_____
Insuance Phone # _____
Group # _____ **Local #** _____

DENTAL HISTORY

Chief Dental Complaint_____
_____
Last Full Mouth X-Rays ?_____

Do you require antibiotics before dental treatment?	**Y**	**N**
Are you currently in pain?	**Y**	**N**
Are you apprehensive about dental treatment?	**Y**	**N**
Have you ever had periodontal/gum treatment?	**Y**	**N**
Do your gums bleed, feel tender, irritated?	**Y**	**N**
Would you like your smile to look different?	**Y**	**N**
Have you ever had jaw problems (eg. Clicking)	**Y**	**N**

Are your teeth sensitive: hot / cold / sweets / pressure
Do you have: headaches / earaches / neck pain

MEDICAL HISTORY

Do you currently have any health problems?	**Y**	**N**
Are you currently under a physician's care?	**Y**	**N**

If yes, for what_____
_____
MEDICATIONS YOU ARE TAKING (Rx, OTC, Herbal)
_____
_____
_____
LIST ANY ALLERGIES:_____
_____
Name of Previous Dentist:_____

DO YOU HAVE OR HAD ANY OF THE FOLLOWING:

High Blood Pressure	**Diabetes**	**Radiation Treatments**	**Psychiatric Treatment**
Heart Disease	**Smoker**	**Cancer**	**Drug/Alcohol Abuse**
Heart Attack (when?_____)	**Liver/Kidney Disease**	**Artificial Joints** (~Hip, Knee)	**Chemotherapy**
Heart Surgery (when?_____)	**Bruise Easily**	**Hepatitis A/B/C**	**Pregnant / Nursing**
Heart Murmur	**Blood Transfusion**	**AIDS/HIV**	**Bleeding Problems**
Angina Pectoris	**Lung Disease:**_____	**Tuberculosis**	**Stroke**
Mitral Valve Prolapse	**Seizures**	**Sinus Problems**	**Autoimmune Disease**
Prosthetic Heart Valve	**Fainting**	**Allergies**	**Any Other Disease / Condition**
Heart Pacemaker	**Stomach Ulcers/Colitis**	**Glaucoma**	**-**_____

I certify that I have read and understand the above questions and have been accurately answered. I understand that providing incomplete or incorrect information can be dangerous to my health:

SIGNATURE **DATE**