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PATIENT INFORMATION

Today's date _____

First Name _____ Last _____ Middle ____ Pref'd/nick name _____

Male or Female Age _____ Birth Date _____ Social Security Number _____-_____-_____

Address _____ City _____ State _____ Zip Code _____

Home phone _____ Cell phone _____ Work phone _____

Are your billing and mailing address the same? Y / N (if not list billing address below)

Address _____ City _____ State _____ Zip Code _____

Email address _____

** Appointment reminders ***(please circle one)*** phone call to your home, cell, or an email **

Emergency Contact _____ Phone number _____

How did you find us?_____

INSURANCE INFORMATION (Primary)

Subscriber _____

ID _____ Group Number _____

Insurance Company _____

Claims mailing address _____

_____

INSURANCE INFORMATION (Secondary)

Subscriber _____

ID _____ Group Number _____

Insurance Company _____

Claims mailing address _____

_____

DENTAL HISTORY

Last Dental Visit _____ Previous Dentist _____ Phone _____

How often do you visit the dentist? ____ regularly ____ occasionally _____ as needed ____ first visit

How often do you brush? ___ regularly (1-2x/day) ___ occasionally (1x/week) ___ rarely (1x/mo. or less)

How often do you floss? ___ regularly (1x/day) ____ occasionally (1x/week) ___ rarely (1x/mo. or less)

Dental Concerns (check all that apply)

__ broken / chipped teeth	___ loose teeth	___ dental phobia	___ tooth pain (generalized)
___ food traps	___ decay	___ difficulty chewing	___ stain / discoloration
__ missing / lost fillings	___ missing teeth	___ bad breath	___ grinding / clenching
___ sensitivity to cold	___ sensitivity to hot	___ sensitivity to bite	___ sensitivity to sweets

___ jaw pain ___ red / puffy gums ___ bleeding gums ___ gum recession
___ frequent headaches ___ cheek biting ___ dry mouth ___ wisdom teeth (3rd molars)
___ pain in temples ___ sleep apnea ___ mouth sores ___ avoid chewing L / R
___ popping / clicking ___ I use a CPAP ___ I am a tobacco user ___ crooked / misaligned teeth
___ difficulty opening/closing ___ I bite my nails ___ I wear a night guard ___ I wear a retainer
___ I am interested in whitening ___ I am interested in cosmetic dentistry
___ I am interested in braces / Orthodontic treatment ___ I am interested in dental implants

Additional dental concerns _____

MEDICAL HISTORY

How is your health in general? ___ great ___ good ___ fair ___ poor
Undergoing medical treatment? Y / N If yes, please specify _____

(please check all that apply)

___ Arthritis ___ Birth defects ___ Psychiatric care ___ Cancer _____
___ Heart murmur ___ Head / face injury ___ Substance abuse ___ Kidney problems
___ Painful joints ___ Allergies (seasonal) ___ Asthma ___ Numbness hands /arms
___ Blood disease ___ Diabetes ___ Intestinal problems ___ Hepatitis B or C
___ Liver problems ___ Low blood pressure ___ High blood pressure ___ Low blood sugar
___ Epilepsy ___ Auto-immune disorder ___ Dizziness / fainting ___ Stent
___ Anemia ___ Deaf / hearing loss (R/L) ___ Wheel chair (able to transfer?) Y / N

___ joint replacement: hip R / L date _____ Knee R / L date_____ other _____
additional medical history not listed _____

Please list all medications:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Have you had an adverse reaction or have had an allergy to any of the following *(check all that apply)*

___ aspirin ___ local Anesthetic ___ iodine ___ Tetracycline ___ Codeine ___ latex ___ sulfa
___ Penicillin ___ Amoxicillin ___ Valium ___ Nitrous Oxide other _____

The above information is correct to the best of my knowledge.

_____ _____
Patient / guardian signature Date