

# Patient Information Form

Name \_\_\_\_\_ Date \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell # \_\_\_\_\_ Home phone \_\_\_\_\_ Birthdate \_\_\_\_\_

Email \_\_\_\_\_ Soc. Security # \_\_\_\_\_

Check Appropriate Box  Minor  Single  Married  Divorced  Widowed  Separated

Patient or parent's employer \_\_\_\_\_ Work phone \_\_\_\_\_

Business address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or parent's name \_\_\_\_\_ Employer \_\_\_\_\_ Work phone \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

If not your general dentist, who is your general dentist? \_\_\_\_\_

Person to contact in case of an emergency \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name of person responsible for this account \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address \_\_\_\_\_ Home phone \_\_\_\_\_

Driver's license # \_\_\_\_\_ Birth Date \_\_\_\_\_ Soc. Security # \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer \_\_\_\_\_ Work phone \_\_\_\_\_

Is this person currently a patient in our office  Yes  No

## Insurance Information

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Soc. Security # \_\_\_\_\_ Date employed \_\_\_\_\_

Name of employer \_\_\_\_\_ Union or local # \_\_\_\_\_ Work phone \_\_\_\_\_

Employer address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Tel. # \_\_\_\_\_ Grp. # \_\_\_\_\_ Policy/I.D.# \_\_\_\_\_

How much is your deductible \_\_\_\_\_ How much have you used \_\_\_\_\_ Max annual benefit \_\_\_\_\_

Do you have any additional insurance  Yes  No If yes, complete the following:

Name of insured \_\_\_\_\_ Soc. Security # \_\_\_\_\_ Date employed \_\_\_\_\_

Name of employer \_\_\_\_\_ Union or local # \_\_\_\_\_ Work phone \_\_\_\_\_

Employer address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Tel. # \_\_\_\_\_ Grp. # \_\_\_\_\_ Policy/I.D. # \_\_\_\_\_

Ins. Co. address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How much is your deductible \_\_\_\_\_ How much have you used \_\_\_\_\_ Max annual benefit \_\_\_\_\_

**X** \_\_\_\_\_  
Signature of patient (or parent, if minor)

\_\_\_\_\_  
Patient number

## MEDICAL HISTORY

Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? \_\_\_\_\_  
Yes No Are you allergic to any medication? \_\_\_\_\_  
Yes No Do you have a history of a major illness? \_\_\_\_\_  
Yes No Have you had any operations? \_\_\_\_\_  
Yes No Have you ever been involved in a serious accident? \_\_\_\_\_  
Yes No Have seen a physician in the last 12 months? Why? \_\_\_\_\_  
Yes No Are you Pregnant? Anticipated delivery date \_\_\_\_\_  
Yes No Do you use any tobacco product? Daily intake? \_\_\_\_\_

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Allergy	Chronic Sinus	Hip or Joint Replacement	Pacemaker
Anemia, Sickle cell disease	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy, Seizures	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer
Mitral Valve Prolapse	Chemical Dependency		

Are there any medical conditions we have not discussed that you feel we should be aware of? \_\_\_\_\_

## DENTAL HISTORY

General Dentist \_\_\_\_\_ Date of last visit \_\_\_\_\_

What concerns you most about your teeth? \_\_\_\_\_

Yes No Are you presently in any dental pain? \_\_\_\_\_  
Yes No Have you ever experienced any unfavorable reaction to dentistry? \_\_\_\_\_  
Yes No Have you ever lost or chipped any teeth? \_\_\_\_\_  
Yes No Have there been any injuries to face, mouth, or teeth? \_\_\_\_\_  
Yes No Is any part of your mouth sensitive to temperature? Where? \_\_\_\_\_  
Yes No Is any part of your mouth sensitive to pressure? Where? \_\_\_\_\_  
Yes No Do your gums bleed when you brush? \_\_\_\_\_  
Yes No Do you have any type of thumb or tongue habit? \_\_\_\_\_  
Yes No Are you a mouth breather? \_\_\_\_\_  
Yes No Have you ever seen an orthodontist? If yes, who and when? \_\_\_\_\_  
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? \_\_\_\_\_  
Yes No Are you aware of clenching your teeth during the day? \_\_\_\_\_  
Yes No Have you ever been told that you grind your teeth? \_\_\_\_\_  
Yes No Do you have "tension" headaches? \_\_\_\_\_  
Yes No Have you ever had any periodontal problems? \_\_\_\_\_  
Yes No Does loss of teeth tend to run in your family? \_\_\_\_\_

How often have you seen the dentist? \_\_\_\_\_

When was your last dental cleaning? \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_