PATIENT INFORMATION

Welcome! Please complete this form, so we may better serve you. Don't hesitate to ask us any questions!

Patient name_____Birthdate _____

Sex: F / M SSN_____ Status: ☐Single ☐Married ☐Other

☐Home/☐Cell # _____ E-mail _____

Home address_____

Emergency contact & number _____

Employer/Occupation_____

How did you hear about us?_____

INSURANCE

Primary dental insurance _____ Policy holder/subscriber _____

Policy holder relationship to patient ☐Self ☐Spouse ☐Child ☐Other

Policy holder DOB _____ Policy holder SSN_____

Do you have secondary insurance? ☐ Yes ☐ No If yes, name_____

Do you consent to getting diagnostic exams and x-rays done? ☐YES ☐NO

Do you consent to having a photo of you/patient in your chart for identification? ☐YES ☐NO

DENTAL HEALTH HISTORY

Date of last visit to dentist_____ Reason for today's visit_____

MEDICAL HEALTH HISTORY

Name of medical doctor_____ Phone number _____

Date of last visit to medical doctor_____

Are you **allergic** to any of the following? ☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metals
☐Latex ☐Local Anesthetics ☐Other _____

Women: Are you? Pregnant/Trying to get pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No
Taking oral contraceptives? ☐ Yes ☐ No

Do you have, or have you had, any of the following? CHECK ANY THAT APPLY.	
☐ Abnormal Bleeding	☐ Heart Attack/Failure
☐ AIDS/HIV Positive	☐ Heart Murmur
☐ Alcohol Abuse	☐ Heart Trouble/Disease
☐ Alzheimer's Disease	☐ Hemophilia
☐ Anemia	☐ Hepatitis A
☐ Arthritis	☐ Hepatitis B or C
☐ Artificial Heart Valve	☐ Herpes
☐ Artificial Joint	☐ High Blood Pressure
☐ Asthma	☐ Hives or Rash
☐ Autoimmune Disease	☐ Kidney Disease/Problems
☐ Blood Disease	☐ Leukemia
☐ Blood Transfusion	☐ Liver Disease
☐ Bronchitis	☐ Lung Disease
☐ Bruise Easily	☐ Mitral Valve Prolapse
☐ Cancer	☐ Neurological Disorders
☐ Chemotherapy	☐ Pain in Jaw Joints
☐ Chest Pains	☐ Parathyroid Disease
☐ Cold Sores/Fever Blisters	☐ Psychiatric Care
☐ Congenital Heart Disease	☐ Radiation Treatments
☐ Convulsions	☐ Renal Dialysis
☐ Cortisone Medication	☐ Rheumatoid Arthritis
☐ Depression/Anxiety	☐ Shingles
☐ Diabetes	☐ Skin Disease
☐ Drug Addiction	☐ Sickle Cell Disease
☐ Emphysema	☐ Sinus Trouble
☐ Epilepsy or Seizures	☐ Stomach/Intestinal Disease
☐ Excessive Bleeding	☐ Stomach Ulcers
☐ Fainting spells/Dizziness	☐ Stroke
☐ Frequent Headaches	☐ Thyroid Disease
☐ GERD/Acid Reflux	☐ Tuberculosis
☐ Glaucoma	☐ Yellow Jaundice
	☐ Smoker? How many packs/day?

Have you ever been **hospitalized** or had a **major operation**? ◯ Yes ◯ No

If yes, please explain:_____

Please list any diseases, conditions, or problems not previously listed.

_____

Are you currently taking any medications? If yes, **please list all the medications you are taking**.

_____

_____

_____

Printed Name

_____ _____

Signature **Date**