

## Patient Information

Name: \_\_\_\_\_ Prefers to be called: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Patient's Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

If a minor: Parent's Name \_\_\_\_\_ Marital Status: M S D W

Parent's Name \_\_\_\_\_

Who does patient live with? \_\_\_\_\_ Have we treated another member(s) of your family? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## Responsible Party Information #1

Name \_\_\_\_\_ Phone \_\_\_\_\_

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

Email Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Employer \_\_\_\_\_

Occupation \_\_\_\_\_ Years employed \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birthdate \_\_\_\_\_

## Responsible Party Information #2

Name \_\_\_\_\_ Phone \_\_\_\_\_

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

Email Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Employer \_\_\_\_\_

Occupation \_\_\_\_\_ Years employed \_\_\_\_\_ Birthdate \_\_\_\_\_

## PRIMARY DENTAL INSURANCE INFORMATION

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Social Security or ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Group Name \_\_\_\_\_ Do you have dual coverage? Yes  No

## SECONDARY DENTAL INSURANCE INFORMATION

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Social Security or ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Group Name \_\_\_\_\_

General Dentist

Name \_\_\_\_\_ Date of last visit \_\_\_\_\_  
\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Family Physician

Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Are you under the care of a physician? Yes  No

Please explain: \_\_\_\_\_

Are you taking any prescription/over-the-counter drugs? Yes  No

Please explain: \_\_\_\_\_

Do you require antibiotic pre-medication prior to dental work/cleanings? Yes  No

Medical History

**Have you ever had any of the following diseases/medical conditions?**

Abnormal bleeding	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hearing Impairment	Yes <input type="checkbox"/> No <input type="checkbox"/>
Allergies to drugs	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Murmur	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hemophilia/Abnormal bleeding	Yes <input type="checkbox"/> No <input type="checkbox"/>
Difficulty breathing	Yes <input type="checkbox"/> No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>
Epilepsy/Seizures/Fainting	Yes <input type="checkbox"/> No <input type="checkbox"/>	Periodontal Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Fever blisters/Herpes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Handicaps/Disabilities	Yes <input type="checkbox"/> No <input type="checkbox"/>	HIV/AIDS	Yes <input type="checkbox"/> No <input type="checkbox"/>

Your current physical health is: Good  Fair  Poor

Please list any serious medical conditions you have had: \_\_\_\_\_

Please list any drug/substances that you are allergic to: \_\_\_\_\_

Are you allergic to Nickel? Yes  No

Do you smoke? Yes  No  Use chewing tobacco? Yes  No

If female, is there any possibility you are pregnant? Yes  No  Trimester \_\_\_\_\_

**If the patient is an adolescent, please answer the following:**

Height: \_\_\_\_\_ Recent growth? Yes  No  How much? \_\_\_\_\_ Weight \_\_\_\_\_

Boys: Has his voice changed? Yes  No  Girls: Has she begun menstruation? Yes  No

Dental History

Do you like to smile? Yes  No  Do your gums ever bleed? Yes  No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes  No

If yes, please list: \_\_\_\_\_

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes  No

Have you ever had an injury to your: Mouth  Teeth  Chin

Do you know if you have any missing/extra permanent teeth? Yes  No

Do you have/have you ever had any speech impediments? Yes  No

If yes, please list: \_\_\_\_\_

Do you generally breathe through your mouth while you sleep? Yes  No

Have you ever had or been evaluated for orthodontic treatment? Yes  No

If yes, when? \_\_\_\_\_

Child Habits

**If patient is a child, does/did your child have any of the following habits?**

Clenching/Grinding teeth	Yes <input type="checkbox"/> No <input type="checkbox"/>	Nursing bottle habits	Yes <input type="checkbox"/> No <input type="checkbox"/>
Lip sucking/Biting	Yes <input type="checkbox"/> No <input type="checkbox"/>	Speech impediments	Yes <input type="checkbox"/> No <input type="checkbox"/>
Mouth breathing	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thumb/Finger sucking	Yes <input type="checkbox"/> No <input type="checkbox"/>
Nail biting	Yes <input type="checkbox"/> No <input type="checkbox"/>		

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

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