EXCELLENCE IN
DENTISTRY

All About You

Patient's First Name: _____________________ Patient's Last Name: ______________________Middle Initial: _____

Patient's Preferred Name: ______________________________ DOB: _____________________ Sex: Male Female

Social Security Number: ____________________________ Marital Status: Single Married Divorced Widowed

Address ____Apt #_____________________________

City ______________________State ______________ Zip Code _____________ Referral Source: ____________________

Home Phone _______________________ Work Phone ____________________ Cell Phone ____________________

Email Address ____

Would you like to receive appointment confirmations via email or text message? Yes No

Responsible Party (if other than the above patient)

First Name: ____________________________ Last Name: ______________________________Middle Initial: _____

Relationship to patient: ______________________________ DOB: _____________________ Sex: Male Female

Address ____

City ________________________________State ______________ Zip Code __________________

Home Phone _______________________ Work Phone ____________________ Cell Phone ____________________

Email Address ____

Primary Insurance Information

Subscriber's Name: ____________________________

DOB: ________________________

Relationship to patient: ____________

Subscriber's Member ID: _______________________

Employer: ______________________________

Insurance Company: ____________________________

Insurance Phone Number: ______________________

Claims Mailing Address: ________________________

City: ___________State: _______ Zip Code: ________

Secondary Insurance Information

Subscriber's Name: ____________________________

DOB: ________________________

Relationship to patient: ____________

Subscriber's Member ID: _______________________

Employer: ______________________________

Insurance Company: ____________________________

Insurance Phone Number: ______________________

Claims Mailing Address: ________________________

City: ___________State: _______ Zip Code: ________

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Dental History

What is the reason for your visit today? ____

Are you currently in pain? _________

Have you ever had any serious/difficult problems with dental treatment? ______ If yes, please explain _________________________
____

Previous Dental Provider's Name: ____ Phone Number: ___________________

When was your last dental cleaning? _______________________________ Were x-rays taken? _______________________________

How many times do you brush a day? __________ How many times do you floss a week? __________Do your gums bleed? ________

Is there anything you would like to change about your smile? ________ If yes, explain _______________________________________

Do you have any concerns about having dental treatment done? ______ If yes, explain _____________________________________

____

Medical History

Are you under a physician's care now?	Yes No	If yes, _________________________________
Have you ever been hospitalized or had a major operation?	Yes No	If yes, _________________________________
Have you ever had a serious head or neck injury?	Yes No	If yes, _________________________________
Are you taking any medications, pills, or drugs?	Yes No	If yes, _________________________________
Do you require a premed (Antibiotic) prior to your dental appointment?	Yes No	If yes, _________________________________
Do you have any allergies?	Yes No	If yes, _________________________________
Are you taking any blood thinners?	Yes No	If yes, _________________________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates for Osteoporosis?	Yes No	If yes, _________________________________
Do you snore or have you been diagnosed with sleep apnea?	Yes No	If yes, _________________________________
Are you pregnant?	Yes No	If yes, due date ________________________
Do you use tobacco?	Yes No	

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Condition		
AIDS/HIV Positive	○ Yes	○ No
Alzheimer's Disease	○ Yes	○ No
Drug / Alcohol Addiction	○ Yes	○ No
Easily Winded	○ Yes	○ No
High Blood Pressure	○ Yes	○ No
High Cholesterol	○ Yes	○ No
Hives or Rash	○ Yes	○ No
Sickle Cell Disease	○ Yes	○ No
Sinus Trouble	○ Yes	○ No
Spina Bifida	○ Yes	○ No
Breathing Problems	○ Yes	○ No
Low Blood Pressure	○ Yes	○ No
Lung Disease	○ Yes	○ No
Tonsillitis	○ Yes	○ No
Tuberculosis	○ Yes	○ No
Congenital Heart Disorder	○ Yes	○ No
Convulsions	○ Yes	○ No

Condition		
Cortisone Medicine	○ Yes	○ No
Diabetes	○ Yes	○ No
Hepatitis B or C	○ Yes	○ No
Herpes (Cold sores)	○ Yes	○ No
Rheumatism	○ Yes	○ No
Scarlet Fever	○ Yes	○ No
Shingles	○ Yes	○ No
Asthma	○ Yes	○ No
Blood Disease	○ Yes	○ No
Frequent Diarrhea	○ Yes	○ No
Frequent Headaches	○ Yes	○ No
Swelling of Limbs	○ Yes	○ No
Thyroid Disease	○ Yes	○ No
Chest Pains	○ Yes	○ No
Cold Sores/Fever Blisters	○ Yes	○ No
Heart Pacemaker	○ Yes	○ No
Heart Trouble/Disease	○ Yes	○ No

Condition		
Hemophilia	○ Yes	○ No
Recent Weight Loss	○ Yes	○ No
Renal Dialysis	○ Yes	○ No
Rheumatic Fever	○ Yes	○ No
Arthritis/Gout	○ Yes	○ No
Artificial Heart Valve	○ Yes	○ No
Artificial Joint	○ Yes	○ No
Fainting Spells/Dizziness	○ Yes	○ No
Frequent Cough	○ Yes	○ No
Leukemia	○ Yes	○ No
Stroke	○ Yes	○ No
Cancer	○ Yes	○ No
Chemotherapy	○ Yes	○ No
Heart Attack/Failure	○ Yes	○ No
Pain in Jaw Joints	○ Yes	○ No
Parathyroid Disease	○ Yes	○ No
Psychiatric Care	○ Yes	○ No

Condition		
Radiation Treatments	○ Yes	○ No
Anaphylaxis	○ Yes	○ No
Anemia	○ Yes	○ No
Emphysema	○ Yes	○ No
Epilepsy or Seizures	○ Yes	○ No
Excessive Bleeding	○ Yes	○ No
Excessive Thirst	○ Yes	○ No
Irregular Heartbeat	○ Yes	○ No
Kidney Problems	○ Yes	○ No
Stomach/Intestinal Disease	○ Yes	○ No
Bruise Easily	○ Yes	○ No
Glaucoma	○ Yes	○ No
Hay Fever	○ Yes	○ No
Osteoporosis	○ Yes	○ No
Tumors or Growths	○ Yes	○ No
Ulcers	○ Yes	○ No
Yellow Jaundice	○ Yes	○ No

I understand the information I have provided to is correct to the best on my knowledge. I also understand and accept my responsibility to inform this office of any changes in my personal information, insurance changes and medical status.

Print patient's name ____ **Date:** ____________________________________

Patient/Guardian's Signature ____