

Patient Information

Date: (mm/dd/yyyy) Email Address:

Patient's Name:
Last First Middle

Address:
Street City State Zip

Home Phone Birth Date Age SS#
(xxx) xxx-xxxx (mm/dd/yyyy) (xxx-xx-xxxx)

If patient is a minor, give parent's or guardian's name

Whom may we thank for referring you to our office?

Responsible Party Information

Name:
Last First Middle Marital Status

Residence:
Street City State Zip

Mailing Address:
Street City State Zip

How long at this address: Home Phone: Work Phone:
(xxx) xxx-xxxx (xxx) xxx-xxxx

Previous Address
(If less than Street City State Zip
3 years)

Social Security Number Birth date Relationship to Patient
(xxx-xx-xxxx) (mm/dd/yyyy)

Employer Occupation # of Years Employed

Dental Insurance Information

Insured's Name Social Security Number
(xxx-xx-xxxx)

Insurance Company Insurance Company Phone Number

Group Number Local Number

Insured's Employer Do you have dual coverage?: Yes No

If Yes: Insured's Name Social Security Number
(xxx-xx-xxxx)

Insurance Company Group Number Local Number

Insured's Employer

Emergency Information

Name of nearest relative not living with you:

Complete Address:

Phone Number: (xxx-xxx-xxxx)

Additional Information

Name of Family Members in Treatment:

Patient's Physician Patient's Dentist

Are you taking any medications?: Yes No

If Yes, please list them:

Have you ever had any of the following diseases or medical problems?

Heart Attack / Stroke	<input type="radio"/> Yes	<input type="radio"/> No	Psychiatric / Learning Problems	<input type="radio"/> Yes	<input type="radio"/> No
High / Low Blood Pressure	<input type="radio"/> Yes	<input type="radio"/> No	Epilepsy / Seizures / Fainting Spells	<input type="radio"/> Yes	<input type="radio"/> No
Diabetes / Tuberculosis (TB)	<input type="radio"/> Yes	<input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes	<input type="radio"/> No
Rheumatic Fever	<input type="radio"/> Yes	<input type="radio"/> No	HIV+ / Aids	<input type="radio"/> Yes	<input type="radio"/> No
Hemophilia / Abnormal Bleeding	<input type="radio"/> Yes	<input type="radio"/> No	Heart Surgery / Pacemaker	<input type="radio"/> Yes	<input type="radio"/> No
Cancer / Chemotherapy / Radiation	<input type="radio"/> Yes	<input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes	<input type="radio"/> No
Kidney Problems	<input type="radio"/> Yes	<input type="radio"/> No	Artificial Bones / Joints	<input type="radio"/> Yes	<input type="radio"/> No
Asthma / Arthritis	<input type="radio"/> Yes	<input type="radio"/> No	Sinus / Breathing Problems	<input type="radio"/> Yes	<input type="radio"/> No
Adenoids / Tonsils Removed	<input type="radio"/> Yes	<input type="radio"/> No	Hepatitis	<input type="radio"/> Yes	<input type="radio"/> No

List any other
medical condition:

Are you aware of any allergies?

Aspirin / Codeine	<input type="radio"/> Yes	<input type="radio"/> No	Penicillin / Tetracycline / Erythromycin / Sulfa	<input type="radio"/> Yes	<input type="radio"/> No
Dental Anesthetics	<input type="radio"/> Yes	<input type="radio"/> No	Latex / Rubber Gloves	<input type="radio"/> Yes	<input type="radio"/> No
Any Metals / Plastics	<input type="radio"/> Yes	<input type="radio"/> No	Other	<input type="radio"/> Yes	<input type="radio"/> No

If "yes" to "Other", please
list other allergies

Have you ever had or been evaluated for Orthodontic treatment?	<input type="radio"/> Yes	<input type="radio"/> No
Have you ever had problems associated with any previous dental work?	<input type="radio"/> Yes	<input type="radio"/> No
Do you now or have you ever experienced pain / clicking / popping noises in your jaw joint?	<input type="radio"/> Yes	<input type="radio"/> No
Has your jaw joint ever locked or felt like it was sticking?	<input type="radio"/> Yes	<input type="radio"/> No
Have you ever had an injury to your mouth / teeth / chin?	<input type="radio"/> Yes	<input type="radio"/> No
Would you say your overall dental health is: <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor		

Authorizations

I authorize this office to affix my name to any and all claims or documents related to any and all dental benefits due me and my dependents through my employment. I authorize payment of dental benefits otherwise payable to me, directly to this office.

I understand that where appropriate, credit bureau reports may be obtained.

I certify that I have read and understand the foregoing questions. To the best of my knowledge, the foregoing questions have been completely and accurately answered. In addition, I will notify the doctor of any change in my health history.

Patient Signature: _____

Parent or Legal Guardian Signature: _____