PATIENT INFORMATION:

NAME: ____
LAST FIRST M

MARRIED SINGLE MINOR MALE FEMALE

ADDRESS: ____
STREET APT# CITY STATE ZIP

PHONE #'S: ____
HOME CELL WORK/OTHER

BIRTHDAY: ____-____-________ SS#: ______________________
MO DAY YEAR

EMAIL: ____

EMPLOYER: ____

PREFERRED COMMUNICATION METHOD: CIRCLE BEST METHOD

PHONE: HOME CELL WORK TEXT OR EMAIL

IF A PHONE NUMBER IS PREFERRED MAY WE LEAVE PATIENT TREATMENT INFORMATION ON A VOICEMAIL MESSAGE? YES NO

MAY WE LEAVE A MESSAGE WITH SOMEONE ELSE AT THE PREFERRED PHONE #? YES NO
IF YES, WHO?

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED IN OUR OFFICE? YES / NO
IF YES, WHOM:

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ______________________

DID YOU FIND US BY ANOTHER METHOD? CIRCLE ANY THAT APPLY

INTERNET SEARCH WEBSITE AD INSURANCE WEBSITE DRIVING BY

FAMILY INFORMATION:

RESPONSIBLE PARTY OR INSURANCE CARRIER: SELF SPOUSE MOTHER FATHER GUARDIAN

NAME: ______________________________ BIRTHDATE: ______________
LAST FIRST M MO DAY YEAR

ADDRESS: ____
STREET APT# CITY STATE ZIP

INSURANCE CPY: ______________________ GROUP#: ______________________

DENTAL HISTORY:

What may we do for you?____

Do you have dental examinations on a routine basis? Yes No Last visit:______________

If you change your teeth/smile, what would you change?_____________________________

____

What would you like your teeth to be like in 20 years?______________________________

Do you grind you teeth? Yes No Does your jaw click or pop? Yes No

Do your gums bleed? Yes No Do you use tobacco? Yes No

MEDICAL HISTORY: Are you currently under a physician's care? Yes No

Who?____________________Why?____

Have you ever been hospitalized or had a major operation?____________________________

Have you ever had a serious injury to your head or neck?_____________________________

Are you on a special diet? Yes No If yes, what?_____________________________________

Are you allergic to any medication? Circle any that apply

Aspirin Penicillin Codeine Acrylic Latex Metal

Any other know allergies (please list)____

WOMEN: PLEASE CIRCLE ANY THAT APPLY PREGNANT TAKING ORAL CONTRACEPTIVE

Have you had, or are you currently experiencing, any of the following? Circle any that apply:

Heart Trouble/Disease	Sinus Trouble	Hepatitis A,B,C	Leukemia
Mitral Valve Prolapse	Asthma	HIV	Recent Blood Transfusion
Artificial Heart Valve	Lung Disease	Drug Addiction	Epilepsy or Seizures
Heart Surgery	Breathing Problem	High Blood Pressure	Fainting or Dizziness
Kidney Problems	Emphysema	Stroke	Glaucoma
Thyroid Disease	Tuberculosis	Blood Disease	Alzheimer's Disease
Arthritis/Gout	Cancer/Cancer Treatments	Bruise Easily/Anemia	Allergies (Pollen/Dust)
Cortisone Medicine	Diabetes	Excessive Bleeding	Mental/Emotional Impairment
Artificial Joint	Hypoglycemia	Sickle Cell Disease	
	Liver Disease	Hemophilia	

Have you ever had a serious disease not mentioned above? Yes No If yes, what?______________

Emergency Contact:_________________________________Phone:______-______-__________

To the best of my knowledge, all the preceding answers are correct:

X:____Date:_________________

Patient Signature (Parent or Guardian)

Reviewed by Provider:_____________________________________Date:_________________