PATIENT INFORMATION FORM

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Today's Date:_________________

Personal History:

Name: Mr./Mrs./Ms./Dr.____
Last First MI

I prefer to be called:____ ☐ Male ☐ Female

Birthdate:____/____/____ **Age:**_____ **SS#:**_______________________________

Home Address: ____
Street Address Apt/Condo #

____
City State Zip Code

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home #: (_____)___________________ Pager/Cell #: (_____)___________________

Work #: (_____)___________________ Ext.: _______

Email Address:____

Employer: ____

Employer's Address: ____

How long there? __________________ Occupation: ___________________________

When & where are the best times to reach you: ___________________________________

Whom may we Thank for referring you? ____

Other family members seen by us: ____

Previous/Present Dentist: ____
(Please Circle)

Last Visit Date: _________________________________

Person Responsible for Account: ____________

Contact Telephone: ________________________

Billing Address: ____________________________

____

Relation: _________________________________

SS#: _____________________________________

Employer: _______________________________

Spousal Information

His/Her Name:________________________

Employer: ___________________________

Work #: (_____)_____________ Ext.: ____

SS #: __________________________

Birthdate____/____/____

Dental Information

Primary Dental Insurance

Insurance Co. Name: ________________________
Insurance Co. Address: ______________________
Insurance Co. Phone #: (____)________________
Group # (Plane, Local or Policy #): _____________
Insured's Name: ____________________________
Relation:________________________
Insured's Birthdate: ____/____/____
Insured's ID #: _________________________
Insured's Employer: ______________________
Employer's Address: ______________________

Secondary Dental Insurance

Insurance Co. Name: ________________________
Insurance Co. Address: ______________________
Insurance Co. Phone #: (____)________________
Group # (Plane, Local or Policy #): _____________
Insured's Name: ____________________________
Relation:________________________
Insured's Birthdate: ____/____/____
Insured's ID #: _________________________
Insured's Employer: ______________________
Employer's Address: ______________________

Emergency Contact

His/Her Name: ______________________________________ Relation: __________________

Work #: (_____)______________________ Home #: (_____)_______________________

Medical History

Have you ever had any of the following diseases or medical problems? (Please circle option that applies)

Y N Anemia / Radiation Treatment
Y N Artificial Bones / Joints / Valves
Y N Arthritis
Y N Asthma
Y N Blood Transfusion
Y N Cancer / Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema / Glaucoma
Y N Epilepsy/Seizures / Fainting Spells
Y N Fever Blisters / Herpes
Y N Heart Attack / Stroke
Y N Heart Murmur
Y N Heart Surgery / Pacemaker
Y N Hemophilia / Abnormal Bleeding
Y N Hepatitis
Y N High / Low Blood Pressure
Y N HIV+ / AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Osteoporosis (or currently taking medication for such)
Y N Psychiatric Problems
Y N Rheumatic / Scarlet Fever
Y N Sever / Frequent Headaches
Y N Shingles
Y N Sickle Cell Disease / Traits
Y N Sinus Problems
Y N Tuberculosis (TB)
Y N Ulcers / Colitis
Y N Venereal Disease

Current Medical Physician:__________________________ **Wk #:**___________________________

Please list any serious medical condition(s) that you have ever had:

____

____

Are you currently taking any prescription medications:_______________________________________

Are you allergic to any of the following?

Y N Aspirin   Y N Erythromycin   Y N Penicillin   Y N Codeine   Y N Jewelry / Metals
Y N Tetracycline   Y N Dental Anesthetics   Y N Latex   Y N Other

Please list any other drugs / materials that you are allergic to:_________________________________

Dental History

Why have you come to the dentist today?

____

____

☐ Yes ☐ No Do you require antibiotics before dental treatment?
☐ Yes ☐ No Are you currently in pain?
☐ Yes ☐ No Have you ever had a serious / difficult problem associated with any previous dental work?
☐ Yes ☐ No Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD)?
Your current dental health is: ☐ Good ☐ Fair ☐ Poor
☐ Yes ☐ No Do you like your Smile?
☐ Yes ☐ No Do your gums ever bleed?
☐ Yes ☐ No Have you ever had periodontal disease?
How many times a week do you floss? ___________ a day do you brush? ____________
Type of bristles? ☐ Hard ☐ Medium ☐ Soft

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. Patient is requested to provide a minimum of 24-hours notice for the cancellation of an appointment, otherwise the patient will be charged for the appointment.

____ ______________________________

Signature Date

Office Use Only

I verbally reviewed the medical / dental information above with the patient named herein. Initials:_____ Date:_____

Doctor's Comments:____

Medical History Update:

1. Date:________ Comments:_______________________________________ Signature:_____________________
2. Date:________ Comments:_______________________________________ Signature:_____________________