Patient Name:_____________________________________ Date of Birth:________________

Home Address:_____________________________City:__________State:____Zip:_________

Home Phone:____________Cell:_____________Work:____________Email:________________

Which of these numbers do you prefer to be contacted?________________________________

Spouse's Name/Number____________________ Emergency Contact:____________________

How did you hear about our office?____

Primary Dental Insurance

Insured
Employer______________________________________

Ins. Co. Name__________________________________

Address:_______________________________________

Tel.#__________________Group#_________________

Insured Name__________________Relation__________

Insured Birthdate__________Insured S.S.#.____________

Secondary Dental Insurance

Insured
Employer______________________________________

Ins. Co. Name__________________________________

Address:_______________________________________

Tel.#__________________Group#_________________

Insured Name__________________Relation__________

Insured Birthdate__________Insured S.S.#.____________

Who will be responsible for your account? (Please circle) Self Spouse Father Mother Other

Name____ Relation_______________ S.S.#.___________________

Address____ Phone#__________________________

Name of previous dentist:_______________________ Date of last dental exam:________________

Name of Physician:_____________________________ Date of last medical exam:________________

Have you been hospitalized in the past three years? If so please explain?_______________________

____

Are you apprehensive about dental treatment? Y N
Do you have difficulty in chewing your food? Y N
Do your gums bleed when you floss? Y N
Do you have sensitive teeth with:
Hot foods or liquids? Y N Cold foods or liquids?Y N
Sweets? Y N
How often do you Brush?________________ Floss?______________________
Do you clench or grind your teeth? Y N
Does it hurt when you open your mouth wide or chew certain foods? Y N
Does your jaw hurt when you wake up in the morning? Y N

HAVE YOU EXPERIENCED OR HAD:

Condition	Y	N	Condition	Y	N
Chest Pain (Angina)	Y	N	Dizziness, Fainting	Y	N
Shortness of Breath	Y	N	Recent Weight Change	Y	N
Headaches	Y	N	Blurred Vision	Y	N
Bleeding Problems	Y	N	Sinus Problems	Y	N
Difficulty Swallowing	Y	N	Frequent Urination	Y	N
Dry Mouth	Y	N	Frequent Nausea	Y	N
Excessive Thirst	Y	N	Contact Lenses	Y	N
Heart Disease, Artificial Valve	Y	N	Stroke	Y	N
Heart Murmur	Y	N	Rheumatic Fever	Y	N
Heart Attack	Y	N	Sexually Transmitted		
High Blood Pressure	Y	N	Disease	Y	N
Asthma or Lung Disease	Y	N	AIDS/HIV	Y	N
Tumors	Y	N	Hepatitis/Liver Disease	Y	N
Arthritis	Y	N	Eye or Skin Disease	Y	N
Anemia	Y	N	Jaundice	Y	N
Herpes/Cold Sores	Y	N	Kidney/Bladder Disease	Y	N
Thyroid Disease	Y	N	Diabetes	Y	N
Ulcers/Stomach Problems	Y	N	Blood Transfusion	Y	N
Pacemaker/Prosthetic Heart	Y	N	Artificial Joints/Implants	Y	N
Chemo/Radiation Treatment	Y	N	Psychiatric Care	Y	N
Cancer	Y	N			

Do you have a **prosthetic joint replacement**? ________If so,what and date of placement____________

Do you have **heart valve replacement**? ________ Date of placement________________________

Allergies to medications________________________ Allergies to latex____________________________

Do you have any other diseases or medical problems that are NOT listed on this form?

____

DO YOU TAKE:

Item	Y	N	Item	Y	N
Recreational drugs	Y	N	Tobacco in any form	Y	N
Medications or natural remedies	Y	N	Alcohol	Y	N

Please list all medications:

____

WOMEN:

Question	Y	N	Question	Y	N
Are you or could you be pregnant	Y	N	Taking birth control pills	Y	N
Are you nursing	Y	N			

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED EVERY QUESTION COMPLETELY AND ACCURATELY. I WILL INFORM MY DENTIST OF ANY CHANGE IN MY HEALTH AND OR MEDICATION. I have read and understand the following: (Please initial next to agreement)

_____________ Appointment policy **_________ Insurance/Financial Agreement**

_____________ HIPAA privacy policy Agreement **_________ Photo for identification purposes (not used for marketing purposes)**

PATIENT'S SIGNATURE_________________________________ **DATE:**__________________________

DOCTOR'S SIGNATURE_________________________________ **DATE:**__________________________