# Patient Information

Name (as recognized by insurance) _____ Home Phone _____ Cell Phone _____

Home Address _____ City _____ State _____ Zip _____

Email Address:_____ How did you find our office?_____

Do you have dental insurance? Y / N Is it through: (check all that apply) □ you □ parent □ spouse

Your Social Security Number/Member ID _____ Spouse/Parent Name & Social Security Number/Member ID _____

Your Date of Birth _____ Spouse/Parent Date of Birth _____

Name of Group Dental Plan _____ Spouse/Parent Group Dental Plan _____

Employer _____ Employer _____

## Dental History

| Y/N | | Y/N | |
|---|---|---|---|
| □ □ | Do you have a specific dental problem? | □ □ | Do you like your smile? |
| □ □ | Do you have dental anxiety? | □ □ | Do you have any jaw pain? |
| □ □ | Do you brush and floss regularly? | □ □ | Do you grind your teeth? |
| □ □ | Do your gums ever bleed? | □ □ | Do you use tobacco? |

## Medical History

| Y/N | | Y/N | | Y/N | | Y/N | | Y/N | |
|---|---|---|---|---|---|---|---|---|---|
| □ □ | Heart Disease/Surgery | □ □ | Bruise Easily/Blood Disease | □ □ | Emphysema | □ □ | Yellow Jaundice | □ □ | Cold Sores |
| □ □ | Heart Murmur | □ □ | Anemia | □ □ | Tuberculosis | □□ | Kidney Problems | □ □ | Fever Blisters |
| □ □ | Irregular Heart Beat | □ □ | Excessive Bleeding | □ □ | Cancer | □ □ | Renal Dialysis | □ □ | Herpes |
| □ □ | Angina/Chest Pain | □ □ | Sickle Cell Disease | □ □ | Radiation Treatments | □ □ | Thyroid Disease | □ □ | Stroke |
| □ □ | Heart Attack/Failure | □ □ | Hemophilia | □ □ | Chemotherapy | □□ | Parathyroid Disease | □ □ | Convulsions |
| □ □ | Congenital Heart Disorder | □ □ | Leukemia | □ □ | Stomach/Intestinal Disease | □ □ | Arthritis/Gout | □ □ | Epilepsy/Seizures |
| □ □ | Mitral Valve Prolapse | □ □ | Recent Blood Transfusion | □ □ | Ulcers | □ □ | Rheumatism | □ □ | Fainting/Dizziness |
| □ □ | Scarlet Fever | □ □ | Swelling of Limbs | □ □ | Recent Weight Loss | □ □ | Pain in Jaw/Joints | □ □ | Glaucoma |
| □ □ | Rheumatic Fever | □ □ | Lung Disease | □ □ | Frequent Diarrhea | □ □ | Cortisone Medicine | □ □ | Tumors/Growth |
| □ □ | Artificial Heart Valve | □ □ | Breathing Problem | □ □ | Diabetes | □ □ | Artificial Joint | □ □ | Nervousness |
| □ □ | Heart Pace Maker | □ □ | Shortness of Breath | □ □ | Excessive Thirst | □ □ | Venereal Disease | □ □ | Psychiatric Care |
| □ □ | Pulmonary Shunt | □ □ | Frequent Cough | □ □ | Hypoglycemia | □ □ | AIDS | □ □ | Alzheimer 's disease |
| □ □ | High Blood Pressure | □ □ | Hay Fever | □ □ | Liver Disease | □ □ | HIV Positive | □ □ | Allergies (Medicine) |
| □ □ | Low Blood Pressure | □ □ | Sinus Trouble | □ □ | Hepatitis A (Infection) | □ □ | Genital Herpes | □ □ | Allergies (Dust/Pollen) |
| □ □ | Bacterial Endocarditis | □ □ | Asthma | □ □ | Hepatitis B or C | □ □ | Drug/Alcohol Addiction | □ □ | Hives/Rash |
| □ □ | Unexplained Fever | □ □ | Bloody Sputum | □ □ | Night Sweats | □ □ | Pregnant | □ □ | Pre-Med |

Are you taking any medications? Please list: _____

If **allergies** to medications or drugs please list _____

Are you under a physician's care now? Y/N For what reason? _____

Physician's Name_____ Phone Number_____

Have you ever been hospitalized? If yes when and for what reason:_____

May we request your health records if necessary? Y / N

Emergency Contact: _____Phone Number:_____

Patient Signature (Parent/Guardian) _____ Date _____

Reviewed By Doctor: _____ Date: _____