PATIENT INFORMATION	CONFIDENTIAL
NAME ______________________________	BIRTHDATE ______________________
ADDRESS ______________________________	HOME PHONE ______________________
CITY ______________ STATE __________ ZIP __________	CIRCLE APPROPRIATE SELECTION:
PATIENT OR PARENT'S EMPLOYER ______________________	MINOR SINGLE MARRIED
BUSINESS ADDRESS ______________________________	DIVORCED WIDOWED SEPERATED
CITY ______________ STATE __________ ZIP __________	WORK PHONE ______________________
IF PT IS A STUDENT, NAME OF SCHOOL ______________________	CELL PHONE ______________________
CITY ______________________ STATE __________	OTHER ______________________
WHOM MAY WE THANK FOR REFERRING YOU? ______________________	EMAIL ______________________
______________________________	
RESPONSIBLE PARTY	
NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ______________	RELATIONSHIP TO PATIENT __________
______________________________	HOME PHONE ______________________
ADDRESS ______________________________	WORK PHONE ______________________
CITY ______________ STATE __________ ZIP __________	CELL PHONE ______________________
EMPLOYER ______________________________	BIRTHDATE ______________________
ADDRESS ______________________________	SS NUMBER ______________________
CITY ______________ STATE __________ ZIP __________	
INSURANCE INFORMATION	
NAME OF INSURED ______________________________	RELATIONSHIP TO PATIENT __________
INSURANCE COMPANY ______________________________	BIRTHDATE ______________________
ADDRESS ______________________________	SS NUMBER ______________________
CITY ______________ STATE __________ ZIP __________	GROUP NUMBER ______________________
	INSURANCE PHONE ______________________
PATIENT NAME ______________________________	PAGE 2

ADDITIONAL INSURANCE

NAME OF INSURED ______________________________

INSURANCE COMPANY ______________________________

ADDRESS ______________________________

CITY ______________ STATE __________ ZIP ________

RELATIONSHIP TO PATIENT ________

BIRTHDATE ______________

SS NUMBER ______________

GROUP NUMBER ______________

INSURANCE PHONE ______________

PATIENT MEDICAL HISTORY

PHYSICIAN NAME ______________________________

- ARE YOU UNDER THE CARE OF A PHYSICIAN YES NO
- HAVE YOU BEEN HOSPITALIZED IN THE LAST FIVE YEARS YES NO
- ARE YOU TAKING MEDICATIONS? INCLUDING OVER THE COUNTER AND PRESCRIPTION. YES NO
- DO YOU USE TOBACCO? YES NO
- DO YOU USE ALCOHOL? YES NO
- DO YOU USE COCAINE OR OTHER DRUGS? YES NO
- DO YOU WEAR CONTACTS? YES NO
- DO YOU HAVE ANY ALLERGIES? YES NO

  ____

  ____
- HAVE YOU EVER HAD A REACTION TO ANESTHETIC? YES NO

EXPLAIN ABOVE: ______________________________

____

____

PHYSICIAN PHONE ______________

DATE OF LAST EXAM ______________

WOMEN ONLY:

- ARE YOU PREGNANT ________
- ARE YOU NURSING ________
- ARE YOU TAING BIRTH CONTROL PILLS ________

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS ABOUT YOURSELF: (*MARK ALL ANSWERS WITH A YES OR NO)*

	YES	NO		YES	NO		YES	NO
HIGH BLOOD PRESSURE	___	___	FREQUENTLY TIRED	___	___	KIDNEY DISEASE	___	___
HEART ATTACK	___	___	ANEMIA	___	___	AIDS/HIV INFECTION	___	___
RHEUMATIC FEVER	___	___	EMPHYSEMA	___	___	STD'S	___	___
SWOLLEN ANKLES	___	___	CANCER	___	___	THYROID PROBLEMS	___	___
FAINING/SEIZURES	___	___	ARTHRITIS	___	___	HEPATITIS A, B OR C	___	___
ASTHMA	___	___	JOINT REPLACEMENT	___	___	ULCERS	___	___
LOW BLOOD PRESSURE	___	___	CHEST PAINS	___	___	RESPIRATORY PROBLEMS	___	___
EPILEPSY/CONVULSIONS	___	___	SHORT OF BREATH	___	___	OTHER ______________		
LEUKEMIA	___	___	STROKE	___	___	______________		
DIABETES	___	___	HAY FEVER/ALLERGIES	___	___	______________		
HEART DISEASE	___	___	TUBERCULOSIS	___	___	______________		
CARDIAC PACE MAKER	___	___	RADIATION THERAPY	___	___	______________		
HEART MURMER	___	___	GLAUCOMA	___	___	______________		
ANGINA	___	___	LIVER DISEASE	___	___			

PATIENT NAME ______________________________

PATIENT DENTAL HISTORY

1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? ____________________
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? ____________________
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? ____________________
4. DO YOU FEEL PAIN IN ANY OF YOUR TEETH? ____________________
5. DO YOU HAVE ANY SORES OR LUMPS IN YOUR MOUTH? ____________________
6. HAVE YOU EVER SUFFERED TRAUMA TO YOUR FACE MOUTH OR JAW? ____________________
7. DOES YOUR JAW EVER CLICK, POP, CRACKLE OR ACHE? ____________________
8. DO YOU HAVE PAIN IN YOUR JAW JOINT, EAR OR SIDE OF THE FACE? ____________________
9. DO YOU HAVE DIFFICULTY OPENING OR CLOSING YOUR MOUTH? ____________________
10. DO YOU HAVE DIFFICULTY CHEWING? ____________________
11. DO YOU HAVE FREQUENT HEADACHES? ____________________
12. DO YOU CLENCH OR GRIND YOUR TEETH? ____________________
13. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? ____________________
14. HAVE YOU HAD PROBLEMS WITH PREVIOUS DENTAL WORK? ____________________
15. HAVE YOU EVER HAD BRACES? ____________________
16. HOW MANY TIMES A DAY DO YOU BRUSH YOUR TEETH? ____________________
17. HOW OFTEN DO YOU FLOSS? ____________________
18. DO YOU USE A MANUAL BRUSH OR ELECTRIC? ____________________
19. DO YOU USE ANY TYPE OF MOUTH RINSE? ____________________

GOALS FOR YOUR MOUTH, TEETH AND SMILE: ________________________

____

____

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD THAT BE? ______________________________________

____

____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

______________________________ ____________
PATIENT SIGNATURE DATE

____
PRINT NAME

____
DENTIST SIGNATURE

____
DATE

____
WITNESS SIGNATURE

____
DATE