Patient Information

Name ____

Prefix *First* *Middle Initial* *Last*

Sex (circle) Female Male Other ____________

Birthdate ____________ Age ________ SSN ____________

Email Address: ______________________________________

Mailing Address ______________________________________

Address *City* *State* *Zip*

Street Address ______________________________________

Address *City* *State* *Zip*

Home phone ________________ Cell phone ____________

Is this number the same for the entire family?	YES	NO	
Is texting to this cell number ok?	YES	NO	
Preferred contact method (circle one)	home #	Cell #	email
Preferred confimation method (circle one)	home #	Cell #	email
Appointment preference (circle all that apply)	AM	PM	Evening
Day Preference (circle all that apply)	M T W TH F		

Your previous dentist	Name	
	Address	
	Phone #	
	Date of last visit	
Your Medical Doctor	Name	
	Address	
	Phone #	
	Date of last visit	
Your preferred pharmacy	Name	
	Address	
	Phone #	

School Information

Are you a student? Full time Part time Not a student

School or University Name ____________________

Dental Information

Reason for today's visit ______________________

Are you in pain? | YES | NO |

If yes, where at? ______________________

If yes, for how long? ______________________

Please indicate any of the following problems by circling "yes" on the corresponding question

Discomfort, clicking, or popping in jaw			YES	
Red, swollen, or bleeding gums			YES	
A removable dental applicance/ including partial dentures			YES	
Blisters/sores in or around the mouth			YES	
Prolonged bleeding from an injury/extraction			YES	
My teeth are sensitive to: *circle all that apply*	Hot	Cold	Sweets	Pressure/biting
Stained teeth			YES	
Locking Jaw			YES	
Bad breath			YES	
Toothache			YES	
Lost/broken filling(s)			YES	
Teeth grinkding/clenching			YES	
Ringing in ears			YES	
Broken/chipped tooth			YES	
Gum disease			YES	
Difficulty closing jaw			YES	
Difficulty opening jaw			YES	
Food caught between teeth			YES	
Swelling/lumps in mouth			YES	

How many times a day do you brush? ______________

Do you floss? | YES | NO |

How would you rate your smile? Worst to best 1 2 3 4 5 6 7 8 9 10

Would you like teeth whiter? | YES | NO |

Medical History

Are you in good health? YES NO

Are you under the care of a physician? YES NO
if yes, explain ______

Has a physician or previous dentist recommended that you take an anitbiotic premedication before your dental appointment? YES NO
if yes, explain ______

Have you had any illness, operation or been hospitalized in the past five years? YES NO
if yes, explain ______

Are you currently taking a blood thinner? YES NO
If yes, name and dosage of medication ______

Have you ever had a serious head or neck injury? YES NO
if yes, explain

Are you receiving pain management treatment?
if yes, explain ______
what medication and dosages are you taking ______

Have you ever taken Phen-Fen or Redux? YES NO

Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, or Evista in the past 12 years? YES NO

Do you smoke? YES NO
Packs per day ______

Do you vape? YES NO
How often ______

Do you use chewing tobacco?	YES	NO
Do you use medical marijuana?	YES	NO
Do you use controlled substances?	YES	NO
Do you use recreational drugs?	YES	NO
Do you have a history of drug abuse?	YES	NO
Do you have a history of alcohol abuse?	YES	NO

Medical History - Page 2

Do you have or have you had any of the following:

Condition	YES | NO	Condition	YES | NO
AIDS	YES | NO	Hepatitis B	YES | NO
Alzheimer's	YES | NO	Hepatitis C	YES | NO
Anemia	YES | NO	High blood pressure	YES | NO
Anaphylaxis	YES | NO	Hypoglycemia	YES | NO
Angina/chest pains	YES | NO	Irregular heart beat	YES | NO
Anxiety	YES | NO	Joint replacement - if yes,	YES | NO
Artifical heart valves	YES | NO	what joint, date of surgery	
Arthritis	YES | NO		
Asthma	YES | NO	Kidney disease	YES | NO
Autoimmune disorder	YES | NO	Leukemia	YES | NO
Back problems	YES | NO	Liver disease/Jaundice	YES | NO
Bleeding problems	YES | NO	Low blood pressure	YES | NO
Blood disorder - if yes, what type?	YES | NO	Mental health problems	YES | NO
		Mitral valve prolapse	YES | NO
Blood transfusion	YES | NO	Osteoporosis/osteopenia	YES | NO
Cancer, if yes what type?	YES | NO	Pneumonia	YES | NO
		Prosthetic implant	YES | NO
Cardiac pacemaker	YES | NO	Radiation treatment , if yes	YES | NO
Chemotherapy	YES | NO	when?	
Congential heart disorder	YES | NO	Renal Dialysis	YES | NO
Congestive heart failure	YES | NO	Respiratory problems	YES | NO
Damaged heart valves	YES | NO	Rheumatic fever	YES | NO
Delay in healing	YES | NO	Sexual transmitted diseases	YES | NO
Diabetes	YES | NO	Sickle Cell disease	YES | NO
Easily winded	YES | NO	Sickle Cell Trait	YES | NO
Emphysema	YES | NO	Sinus trouble	YES | NO
Epilepsy	YES | NO	Sleep apnea	YES | NO
Fainting spells	YES | NO	Snoring	YES | NO
GI troubles	YES | NO	Stroke	YES | NO
Glaucoma	YES | NO	Stomach ulcers	YES | NO
Headaches	YES | NO	Swollen neck glands	YES | NO
Heart attack(s)	YES | NO	Swollen ankles	YES | NO
Heart murmur	YES | NO	Thyroid disease	YES | NO
Heart surgery	YES | NO	Tuberculosis	YES | NO
Hemophilia	YES | NO	Tumors	YES | NO
Hepatitis A	YES | NO	Use CPAP machine	YES | NO

Medical History - Page 3

For Women Only

Is there a possibility of pregnancy?	YES | NO	Expected delivery date ______
Are you nursing?	YES | NO	

Medications

Are you taking any prescription medications, vitamins, minerals, supplements or over the counter medications? YES | NO

Please list any medications, vitamins, minerals or supplements you are currently taking

	Medication Name	Dosage	Frequency	Reason taking medication
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

ALLERGIES

Are you allergic or had a reaction to?

Aspirin	YES | NO	NSAID's	YES | NO
Codeine	YES | NO	Nut Allergy	YES | NO
Ibuprofen	YES | NO	Penicillin/Amoxicillin	YES | NO
Iodine	YES | NO	Red Dye	YES | NO
Latex	YES | NO	Sulfa Drugs	YES | NO
Local Anesthetic	YES | NO		

Do you have any food allergies:	YES | NO	*Please list*	
Do you have any other known allergies?	YES | NO	*Please list*	

Are you allergic to nickel?	YES | NO
Are you allergic to any other metals?	YES | NO

EMERGENCY CONTACT

Contact Name	Contact Number	Relationship to Patient

Insurance Information

Employment Status: Full Time ______ Part Time ______ Retired ______ Not ______

Marital Status: Married ______ Divorced ______ Widow ______ Single ______
Seperated ______

Responsible party for your account: Self ______ Father ______ Mother ______ Spouse ______
Other ____________

Responsible Party *(if not patient)* Name ______________________________
First *Middle Initial* *Last*

Social Security Number ____________ Date of Birth ________ Phone ____________

____
Address *City* *State* *Zip*

Employer Name ______________________________ Phone ____________

____
Address *City* *State* *Zip*

PRIMARY INSURANCE

Insurance Company Name ______________________________

Insurance Address ______________________________
Address *City* *State* *Zip*

Subscriber Name ____________ Date of Birth ____________

Subscriber Gender Male ______ Female ______ Other ______

Subscriber ID ____________ Group Number ____________

Subscriber Address ______________________________
Address *City* *State* *Zip*

SECONDARY INSURANCE (If Any)

Insurance Company Name ______________________________

Insurance Address ______________________________
Address *City* *State* *Zip*

Subscriber Name ____________ **Date of Birth** ____________

Subscriber Gender Male ______ Female ______ Other ______

Subscriber ID ____________ **Group Number** ____________

Subscriber Address ______________________________
Address *City* *State* *Zip*