

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____
 Soc. Sec. # _____ If Patient is a Minor, give Parent's or Guardian's Name _____ TODAY'S DATE _____
 Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____
 RESIDENCE Street _____ Apt. # _____ City _____ State _____ Zip _____
 MAILING ADDRESS Street _____ Apt. # _____ City _____ State _____ Zip _____
 HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ CELL PHONE _____
 WORK PHONE _____ E-MAIL _____
 PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City _____ State _____ Zip _____ How Long _____
 SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT _____
 EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____
LAST FIRST MIDDLE
 EMPLOYER _____ OCCUPATION _____ () NO. YEARS EMPLOYED
 SOC. SEC. # _____ BIRTHDATE _____
 HOME PH. _____ CELL PH. _____
 WORK PH. _____ E-MAIL _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____ RELATIONSHIP _____
 ADDRESS _____ CITY, STATE _____
 HOME PH. _____ CELL PH. _____
 WORK PH. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____
 Insurance Co. _____ E-MAIL _____
 Insurance Co. Address _____
 Insured's Employer _____
 Insured's Soc. Sec. # _____ Group # _____ Local # _____

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name _____
 Insurance Co. _____ E-MAIL _____
 Insurance Co. Address _____
 Insured's Employer _____
 Insured's Soc. Sec. # _____ Group # _____ Local # _____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY		YES	NO	*MEDICAL HISTORY*		YES	NO																																																																																																																																																																																				
HOW LONG SINCE you have seen a dentist?				Do you have any CURRENT HEALTH PROBLEMS?																																																																																																																																																																																							
Last COMPLETE Dental Exam, Date: _____				Are you under a PHYSICIAN'S CARE now? <input type="checkbox"/> <input type="checkbox"/>																																																																																																																																																																																							
Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic) _____				For what? _____																																																																																																																																																																																							
Are you having PROBLEMS now? <input type="checkbox"/> <input type="checkbox"/>				What MEDICATIONS are you currently taking? _____																																																																																																																																																																																							
WHAT?																																																																																																																																																																																											
Is your present dental health POOR? <input type="checkbox"/> <input type="checkbox"/>				Have you ever taken Fen-Phen/Redux? <input type="checkbox"/> <input type="checkbox"/>																																																																																																																																																																																							
Do you wear DENTURES? (Partials or Full) <input type="checkbox"/> <input type="checkbox"/>				Are you PREGNANT? <input type="checkbox"/> <input type="checkbox"/>																																																																																																																																																																																							
Are you UNHAPPY with your dentures? <input type="checkbox"/> <input type="checkbox"/>				Do you use cigars/cigarettes, pipe or chewing tobacco? (circle) <input type="checkbox"/> <input type="checkbox"/>																																																																																																																																																																																							
Would you like to know more about PERMANENT REPLACEMENTS? <input type="checkbox"/> <input type="checkbox"/>				PLEASE ✓ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:																																																																																																																																																																																							
Are you APPREHENSIVE about dental treatment? <input type="checkbox"/> <input type="checkbox"/>				<table border="0"> <tr> <td></td> <td>YES</td> <td>NO</td> <td></td> <td>YES</td> <td>NO</td> <td></td> <td>YES</td> <td>NO</td> </tr> <tr> <td>AIDS/HIV Pos.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Fainting</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Psychiatric care</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Anaphylaxis</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Food allergies</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Rapid weight gain/loss</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Anemia</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Glaucoma</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Radiation treatment</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Arthritis (Rheumatism)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Headaches</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Respiratory disease</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Artificial heart valves</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Heart murmur</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Rheumatic/scarlet fever</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Artificial joints</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Heart problems (please describe)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Shingles</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> 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<td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Cancer</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>High blood pressure</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Surgical implant</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Chemical dependency</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Jaw pain</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Swelling of feet or ankles</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Chemotherapy</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Kidney disease or malfunction</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Thyroid disease or malfunction</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Circulatory 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Name of Previous Dentist: _____				ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?																																																																																																																																																																																							
City: _____ State: _____				Aspirin _____ Local Anesthetic _____ Erythromycin _____ Latex (balloons, gloves, etc.) _____ Nitrous Oxide _____ Codeine _____ Penicillin _____																																																																																																																																																																																							
How do you feel about your teeth?				Are you aware of being allergic to any other medications or substances? If yes, please list: _____																																																																																																																																																																																							
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.				Is there any other Medical or Dental information that you feel I should know about? _____																																																																																																																																																																																							
FEAR of pain # _____ LACK of concern # _____				FAMILY PHYSICIAN _____ PHONE _____ E-MAIL _____																																																																																																																																																																																							
COST of treatment # _____ MISSING work time # _____																																																																																																																																																																																											