

Date \_\_\_\_\_

# Confidential Responsible Party Information

ABC

Name \_\_\_\_\_ Marital Status \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_  
Street City State Zip

How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Previous Address (if less than 3 yrs.) \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

**Spouse's Name** \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

## Confidential Patient Information

Patient's Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## Insurance Information

Policy Holder's name \_\_\_\_\_ and Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Union Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

Do you have dual coverage?      No       Yes       If yes:

Policy Holder's name \_\_\_\_\_ and Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Union Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

## Emergency Information

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone \_\_\_\_\_ Relationship: \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained. If I cancel/reschedule my appointment in less than 24 working hours, I will pay \$25 for every 30 minutes of scheduled time.

Signature (parent's signature if minor) \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_

# Dental History

Why have you come to the dentist today? \_\_\_\_\_

Are you currently in pain?  Yes  No

Have you ever had a serious / difficult problem associated with any previous dental work?  Yes  No

Have you ever had gum treatment?  Yes  No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?  Yes  No

Do you like your smile?  Yes  No

How many times a week do you floss? \_\_\_\_\_

How many times a day do you brush? \_\_\_\_\_ How long do you use a tooth brush before replacing it? \_\_\_\_\_

Type of bristles?  Hard  Medium  Soft

Are your teeth sensitive to heat, cold, or anything else? \_\_\_\_\_

Have you lost any teeth?  Yes  No If yes, why? \_\_\_\_\_

## Medical History

Your current physical health is:  Good  Fair  Poor

Are you currently under the care of a physician?  Yes  No Please explain: \_\_\_\_\_

Do you smoke or use tobacco in any other form?  Yes  No If yes, how much for how long? \_\_\_\_\_

Are you taking any prescription / over-the-counter drugs?  Yes  No

Please list each one \_\_\_\_\_

**For Women:** Are you taking birth control pills?  Yes  No Are you pregnant?  Yes  No Week #: \_\_\_\_\_

Are you nursing?  Yes  No

## Have you ever had any of the following diseases or medical problems?

- |   |  |
|---|--|
| <p>Anemia / Radiation Treatment ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>High / Low Blood Pressure ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack / Stroke ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Surgery / Pacemaker ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Murmur ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Congenital Heart Defect ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mitral Valve Prolapse (MVP) ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic / Scarlet Fever ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy / Seizures ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting Spells ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tuberculosis (TB) ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Artificial Bones / Joint ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Artificial Valves ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty Breathing ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Arthritis ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Emphysema / Glaucoma ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood Transfusion ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hemophilia / Abnormal Bleeding ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer / Chemotherapy ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>HIV + / AIDS ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Problems ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fever Blisters / Herpes ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Shingles ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Venereal Disease ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Drug / Alcohol Abuse ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ulcers / Colitis ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Severe / Frequent headaches ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Psychiatric Problems ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sinus Problems ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hospitalized for Any Reason ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|---|--|

## Are you allergic to any of the following?

- |  |  |   |
|--|--|---|
| <p>Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Codeine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dental Anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Erythromycin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tetracycline <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Penicillin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Latex <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any Metal / Plastic <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|--|---|

Please list any other drugs that you are allergic to: \_\_\_\_\_