Patient Name ______________________ Date of Birth ______________________

Parents Name (If Minor) ______________________ Home Phone# (   ) ______________________

Address ______________________ Cell # (   ) ______________________

City/State/Zip ______________________

Social Security # ______________________ E-mail Address ______________________

Person Responsible for Acct. ______________________

Address ______________________ City/State/Zip ______________________

DENTAL INSURANCE

Employer's Name ______________________ Business Phone # (   ) ______________________

Insurance Company Name ______________________ Group # ______________________

Policy Holder's Name ______________________ SS#/ID# ______________________

Date of Birth ______________________

SECONDARY INSURANCE

Employer's Name ______________________ Business Phone # (   ) ______________________

Insurance Company Name ______________________ Group # ______________________

Policy Holder's Name ______________________ SS#/ID# ______________________

Date of Birth ______________________

DENTAL HISTORY

Last Dental Visit ____________ Last Dental Cleaning ____________ Last Full Mouth X-rays ____________

Reason for Today's Visit ______________________

Previous Dentist's Name ______________________ Phone # (   ) ______________________

Address ______________________ City ______________ State ________

How often do you brush your teeth? ______________ How often do you floss? ______________

Are you interested in changing anything about your teeth/smile?

____

____

Do your gums bleed when brushing?	Yes ____ No _____	Do they bleed while flossing?	Yes ____ No _____
Do you have any problems chewing?	Yes ____ No _____	Are any teeth loose?	Yes ____ No _____
Are your teeth sensitive to temperature?	Yes ____ No _____	Explain ______________________________	
Are you concerned about bad breath?	Yes ____ No _____	Do you use mouthwash/rinse?	Yes ____ No _____

Do you clench or grind your teeth? Yes ____ No _____

Do you have frequent headaches around ears or eyes? Yes ____ No _____

Have you ever had clicking or pain in your jaw? Yes ____ No _____

Are you subject to prolonged bleeding? Yes ____ No _____

Do you smoke or use smokeless tobacco? Yes ____ No _____

MEDICAL HISTORY

Heart Disease	Yes/No	Diabetes	Yes/No
Heart Murmur	Yes/No	Hypoglycemia	Yes/No
Rheumatic Fever	Yes/No	Epilepsy/History of Seizures	Yes/No
Mitral Valve Prolapse	Yes/No	Ulcers	Yes/No
Artificial Heart Valve/Pacemaker	Yes/No	Cancer	Yes/No
Congenital Heart Disease	Yes/No	Radiation Therapy	Yes/No
Stroke	Yes/No	Chemotherapy	Yes/No
Arthritis/Rheumatism	Yes/No	Blood Disorder	Yes/No
Asthma	Yes/No	Hepatitis A B C (circle)	Yes/No
Hay Fever/allergy/hives	Yes/No	A.I.D.S./H.I.V. Positive	Yes/No
Sinus Trouble	Yes/No	Artificial joints (hip, knee, etc.)	Yes/No
High Blood Pressure	Yes/No	Nervous/anxious	Yes/No
Low Blood Pressure	Yes/No	Psychiatric/psychological care	Yes/No
		Sleep apnea	Yes/No

ALLERGIES

Are you allergic to Penicillin?	Yes ____ No _____	Are you allergic to Latex?	Yes ____ No _____
Are you allergic to any other medication?	Yes ____ No _____	Are you allergic to Red Dye?	Yes ____ No _____

If so, please list ____

MEDICATIONS

List all current Medications and the dose ______________________________

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

WOMEN

Are you pregnant? Yes ____ No _____ Due Date __________

Oral Contraceptives? Yes ____ No _____ Nursing? Yes ____ No _____

Please list any other conditions/concerns that are not listed above: ______________________________

____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge.

Parent/Guardian Signature ______________________________ Date ______________