Reason for Visit:

____

How did you hear about our office?

____

Name: ___________________________________**Preferred:** ____________________________

DOB: ____________**Sex:** _______ **Social Security:** ____________________________________

Marital Status: Single _____ **Married** _____ **Spouse Name:** ________________________________

Home Address:______________________**City:** _______________________ **Zip:** _____________

Home Ph: _________________________**Cell Ph:** __________________ **Other:** _____________

Email Address: ____

What is your preferred method of contact? __ **Home** __ **Cell** __ **Other** __ **Email**

Guardian (If patient is under age of 18)

____

Emergency Contact: _____________________________ **Phone Number:** _____________________

Insurance:

Are you covered by a Dental Insurance Plan? __ **Yes** __ **No**

Name of Insurance:

____

Employer:

____

Policy Holder: _______________________**DOB:**____________ **Social Security:** ______________

ID# ____________________________**Group #**___________**Insurance Phone Number:** __________

Insurance Mailing Address:

Have you had recent dental care with this plan? __ **Yes** __ **No**

Dental History | ***Medical History***

Are your teeth sensitive to:

Hot	Y	N
Cold	Y	N
Sweets	Y	N
Biting Pressure	Y	N

Do your gums bleed when:

Brushing	Y	N
Flossing	Y	N

In regards to your jaw:

Popping	Y	N
Clicking	Y	N
Headaches	Y	N

Do you notice:

Grinding	Y	N
Clenching	Y	N

Recent Extractions	Y	N
Do you feel you will eventually need dentures?	Y	N
Do you need to premed with an antibiotic?	Y	N

How would you rate your dental anxiety?	H	M	L

Would you be interested in sedation dentistry?	Y	N
Do you have an allergy to latex?	Y	N
Any medical allergies?	Y	N

Please list: ____________________________________

Primary Care Physician?________
Phone Number: ______________________________
Date of last medical exam: _____________________
Do you currently see a specialist? _______________
If yes, reason? _________________________________
Name of Specialist: _____________________________
Phone Number: _________________________________
Have you been hospitalized in the last 5 years?
Reason: ______________________________________

Do you have a history of or currently have:

Blood Pressure H L	Y	N
Heart Attack	Y	N
Stroke	Y	N
Hay Fever	Y	N
Asthma	Y	N
Sinus Problems	Y	N
Diabetes	Y	N
Blood Disorder	Y	N
Anemia	Y	N
Kidney Disease	Y	N
Liver Disease	Y	N
Tuberculosis	Y	N
Emphysema	Y	N
Other Respiratory Problems	Y	N
Arthritis	Y	N
Artificial joints/implants	Y	N
Ulcers	Y	N
Stomach Disorders	Y	N
Are you pregnant?	Y	N
Thyroid Condition	Y	N
Psychological Problem	Y	N

Hepatitis	Y	N

If yes, what type: ______________________

Drug Addiction	Y	N
Alcohol Addiction	Y	N
Hearing Impairment	Y	N
Cancer	Y	N

If yes, what type: ______________________

Radiation Therapy	Y	N
Chemotherapy	Y	N

• Are you currently taking any medications?	**Y**	**N**	HIV/AIDS	Y	N
			Do you smoke tobacco?	Y	N
Please list: ______________________________________			Do you chew tobacco?	Y	N

____

____

____

____

What Pharmacy do you use? ________________________
Phone number: ___________________________________

____

Patient or Guardian (If under the age of 18)

____

Date