

Date \_\_\_\_\_

**Confidential Patient Information**

**A B C**

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

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

Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex \_\_\_\_\_

Sports or Hobbies \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained

Signature (Parent's signature if minor) \_\_\_\_\_ Updates (date & initial) \_\_\_\_\_

**Confidential Responsible Party Information**

Parent/Guardian Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle

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

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

Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Previous Address (if less than 3 yrs.) \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Marital Status \_\_\_\_\_  
Street City State Zip

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

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

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

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

Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

**Insurance Information**

Policy Holder's Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Signature \_\_\_\_\_

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 \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Signature \_\_\_\_\_

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: \_\_\_\_\_

**MEDICAL/DENTAL HISTORY**

Latest Revision: 5/15/2009

Physician's Name: \_\_\_\_\_

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

General Dentist's Name: \_\_\_\_\_

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

Are you currently under any medical treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently taking any medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have allergies? (Sulphur, Penicillin, Novocaine, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a latex allergy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a nickel allergy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever taken bisphosphonates, etc. for Osteoporosis (i.e. Fosamax)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a heart condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you pre-medicate prior to dental visits?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have sleep apnea?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you bleed easily?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there a tendency to faint or become dizzy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you smoke or chew tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have pain, clicking, and/or popping noises in your jaw?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you aware of either clenching or grinding of teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have frequent headaches? If so, how frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have ear problems? (Aches, ringing, dizziness, fullness)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have difficulty breathing through the nose?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have habits such as nail biting, finger or thumb sucking, lip or cheek biting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you aware of any speech problems, or are you in speech therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had your tonsils and/or adenoids removed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been informed of any extra or missing teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have there been any injuries to the teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any permanent teeth extracted?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have we treated any other family members? Name(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Has there been any history of any of the following:

- Joint Swelling   
  Asthma   
  TB   
  Aids   
  Kidney Disorder   
  Liver Condition  
 Epilepsy   
  Rheumatic Fever   
  Other major illnesses: \_\_\_\_\_

In your own words what is your chief concern? \_\_\_\_\_

Which of the following categories is **most** important to you (PLEASE MARK ONE)?

- Quality   
  Cost   
  Discomfort   
  Time

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature

**OTHER INFORMATION: Siblings and/or children under age 18**

	Sibling/Child Name:	Birth Date:
1.		
2.		
3.		
4.		

**FOR OFFICE USE ONLY**

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\_\_\_\_\_

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\_\_\_\_\_