

Date: _____

Confidential Patient Information

A B C

Patient's Name: _____ M/ S / D/ W
Last First Middle Marital Status

Who's the Responsible Party? Patient or Spouse or Other

Address: _____
Street City State Zip

Patient's Email _____ how long at the above address? _____ Own or Rent

List Previous address if less than 3 Years _____
Street City State Zip

Home Phone # _____ Cell Phone # _____

Date of Birth: _____ Age _____ Social Security # _____

Employer: _____ Occupation: _____ Yrs. Employed _____

List any family members seen by our practice: _____

Whom can we thank for referring you to our office? _____

General Dentist: _____ Office # _____

Spouse information

Name: _____
Last First Middle

Date of Birth: _____ Age _____ Social Security # _____

Employer: _____ Occupation: _____ Yrs. Employed _____

Insurance Policy Holder Is the -- Patient – Spouse – Both – Other (Please Circle)

Insurance Company _____

Insurance Co. Address _____ Phone# _____

Group # _____ Insured ID# _____ Union Local # _____

Emergency Information

Emergency Contact: _____ Phone # _____

Address: _____ Relationship _____

Date: _____

Confidential Patient Information Medical History

A B C

Has the patient had any of the following medical problems? Please circle Y/N for each medical condition listed.

Heart disease/problems	Y N	Heart Murmur	Y N	Cancer /Radiation	Y N
Anemia	Y N	Diabetes	Y N	High/low Blood Pressure	Y N
Chemotherapy	Y N	Hives/Rash	Y N	Dizziness/ Fainting/ Seizures	Y N
Asthma	Y N	Hepatitis A, B, or C	Y N	Hemophilia/Abnormal Bleeding	Y N
Osteonecrosis of jaw	Y N	Lung disease	Y N	Tuberculosis	Y N
Breathing problems	Y N	Epilepsy	Y N	Tumors/growths	Y N
Kidney /liver problems	Y N	Shingles	Y N	Rheumatism / Arthritis	Y N
AIDS/HIV	Y N	Nervousness	Y N	Herpes /Venereal Disease	Y N
Fever Blister	Y N	Allergies	Y N	Alcoholism/ Drug Addiction	Y N

Stomach/intestinal disease/ulcers **Y N**

Are there any allergies to any of the following?

Penicillin	Y N	Tetracycline	Y N	Latex	Y N	Erythromycin	Y N	Metal/plastic	Y N
Aspirin	Y N	Dental Anesthetics	Y N	Codeine	Y N	Other: _____			

Female Patients Only: Is there any possibility of pregnancy? **Y N**

Are you currently being treated by a physician's? **Y N** If so, please explain _____

Are prescription / over the counter drugs being taken? Vitamins? **Y N** Please list: _____

What is your current health condition? Good _____ Fair _____ Poor _____

Are you aware of any missing/extra teeth? **Y N** Have the tonsils and/or adenoids been removed? **Y N**

Any past or present discomfort/clicking in the jaw joint (TMJ)? **Y N** Have you ever been told you need antibiotics prior to dental treatment? **Y N** Explain: _____

Any past injuries to the Mouth __ Chin__ Teeth__ _____

Do you have any of the following habits apply?

Speech problems **Y N** Constant mouth breathing **Y N** Lip/cheek biting **Y N**

Clenching / Grinding teeth **Y N** Tongue thrust swallow **Y N** Other _____

Please list any medical condition/ problem not listed above _____

To the best of my knowledge the preceding answers are correct. If there are any changes to my health status or if my medicines change I shall inform the dentist and staff at the next appointment. This Office reserves the right to verify the credit status of potential patients prior to extending credit for treatment fees. While the office accepts insurance, I understand that I am responsible for payment of services rendered.

Patient's signature _____ Date _____

Updates (date & initial) _____

FOR OFFICE USE

Medical History reviewed	_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____
	Init. Date	Init. Date	Init. Date	Init. Date

Comments _____