Date:_____ **Confidential Patient Information** A B C

Patient's Name: _____M / F
Last First Middle Nickname
Date of Birth_____Age_____

Address: _____
Street City State Zip
Hobbies/Interests_____

List any family members seen by our practice:_____

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

General Dentist: _____Office # _____

Responsible Party Information

Name: _____M / S / D/ W
Last First Middle Marital Status

Address: _____
Street City State Zip
Email _____ Home Phone #_____Cell # _____

How long at the above address? _____ Own or Rent

List Previous address if less than 3 Years_____
Street City State Zip

Date of Birth: _____Age_____ Social Security # _____

Employer: _____Occupation:_____Yrs. Employed_____

Spouse Information

Name: _____Date of Birth: _____ SSN:_____
Last First

Email _____ Home Phone #_____Cell Phone # _____

Employer: _____Occupation:_____Yrs. Employed_____

Insurance Policy Holder is -- Responsible Party – Spouse – 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** A B C

Medical History

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/Emotional	**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: _____
_____

Teenagers: Has the Patient reach puberty? **Y N**
F**emale Patients Only:** Has Menstruation begun? **Y N** Is there any possibility of pregnancy? **Y N**

Is your child 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 child's health condition? Good_____ Fair_____ Poor_____
Are you aware of any missing/extra teeth**? Y N**
Any past or present discomfort/clicking in the jaw joint (TMJ)?**Y N**
Have the tonsils and/or adenoids been removed? **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__ _____

Does the Patient have any of the following habits apply?

Thumb/finger habit **Y N**
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 child's 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.

Parent's signature _____ Date _____

Updates (date & initial) _____

FOR OFFICE USE

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

Comments_____
_____