PATIENT INFORMATION

DENTIST: _____

PHYSICIAN: _____

WELCOME TO OUR OFFICE!

Date _____

Patient's Name: _____ (Last Name) _____ (First Name) _____ (M. I.)

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone _____ Birth Date _____ Social Security # _____

If patient is minor, give parent or guardian's name _____

Patient Email Address _____ Responsibly Party E-mail address _____

RESPONSIBLE PARTY INFORMATION

Name: _____ (Last Name) _____ (First Name) _____ (M. I.) _____ (Marital Status)

Residence: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Mailing Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

How long at this address _____ Home Phone _____ Work Phone _____

Previous address (if less than 3 years): _____ (Street) _____ (City) _____ (State) _____ (Zip)

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ No. of Years Employed _____

Spouse's Name: _____ (Last Name) _____ (First Name) _____ (M.I.) _____ (Relationship to Patient)

Employer _____ Occupation _____ No. of Years Employed _____

Spouse's Name: _____ (Last Name) _____ (First Name) _____ (M.I.) _____ (Relationship to Patient)

INSURANCE INFORMATION

Insured's Name _____ Date of Birth _____ Insured's Soc. Sec # _____

Insured's Company _____ Group # _____ Local # _____

Insurance Company Address _____

Do you have Dual Coverage? Yes ☐ No ☐ If yes, please continue: _____

Secondary Insured's Name _____ Date of Birth _____ Insured's Soc. Sec # _____

Insured's Company _____ Group # _____ Local # _____

Insurance Company Address _____

Insured's Employer _____

EMERGENCY INFORMATION

Name of nearest relative not Living with you _____

Complete Address _____

Phone _____ Relationship to Patient _____

Signature (Parent's signature, if minor) _____ Date _____

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

MEDICAL HEALTH HISTORY

PLEASE CHECK ANY OF TH FOLLOWING FOR WHICH THE PATIENT HAS BEEN DIAGNOSED OR TREATED: PLEASE COMMENT IF NECESSARY.

☐ ADENOIDS ☐ ANEMIA ☐ ARTHRITIS ☐ ASTHMA ☐ POLIO
☐ EMOTIONAL PROBLEMS ☐ EPILEPSY ☐ BONE DISORDERS
☐ DIABETES ☐ ENDOCRINE ☐ PNEUMONIA ☐ POOR HEALTH
☐ PROLONGED BLEEDING ☐ RHEUMATIC ☐ TUBERCULOSIS
☐ FAINTING, DIZZINESS ☐ FEVER HEPATITIS ☐ NONE OF THESE

WEIGHT _____ HEIGHT _____

DOES PATIENT HAVE TENDENCY TO COLDS? YES ☐ NO ☐
SORE THROATS? YES ☐ NO ☐ EAR INFECTIONS? YES ☐ NO ☐

HAVE TONSILS OR ADENOIDS BEEN REMOVED? YES ☐ NO ☐ WHAT AGE? _____
BROKEN BONES? PLEASE LIST. DID THEY HEAL SATISFACTORILY?
_____
DOES PATIENT BLEED EASILY? YES ☐ NO ☐
HAVE HIGH FEVER WITH CHILDHOOD DISEASES? YES ☐ NO ☐
ANY PSYCHOLOGICAL COUNSELING? _____
_____
OTHER ILLNESSES, CONDITIONS, ALLERGIES, ETC.: _____
_____
DID PATIENT EVER HAVE AN ALLERGY TO ANY DRUG OR MEDICATION: YES ☐ NO ☐
YES, REMARKS _____
TO THE BEST OF YOUR KNOWLEDGE, IS THE PATIENT IN GOOD HEALTH? YES ☐ NO ☐

IF PATIENT IS UNDER THE CARE OF A PHYSICIAN FOR A SPECIFIC CONDITION OR IS TAKING ANY MEDICATIONS, PLEASE EXPLAIN AND LIST.

_____
_____
_____
_____
_____
_____

DENTAL HEALTH HISTORY

HAS THE PATIENT HAD ANY INJURIES TO THE FACE?
☐ MOUTH ☐ TEETH ☐ FACE

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? YES ☐ NO ☐
UNTIL WHAT AGE? _____
DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? YES ☐ NO ☐
IS THE PATIENT A MOUTH-BREATHER?

WHILE AWAKE? _____ WHILE ASLEEP? HAS _____

THE PATIENT HAD ANY TEETH REMOVED AT ANY TIME BY A DENTIST? YES ☐ NO ☐
WHICH TEETH? _____
DOES THE PATIENT (GRIND) THE TEETH OR (BITE) HIS OR HER LIP? YES ☐ NO ☐
PLEASE UNDERLINE _____

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? YES ☐ NO ☐
DOES FACE AND MOUTH RESEMBLE: ☐ MOTHER ☐ FATHER ☐ NEITHER

DO YOU MAKE REGULAR VISITS TO THE DENTIST? YES ☐ NO ☐
WHEN LAST? _____

HOW OFTEN DOES PATIENT BRUSH HIS/HER TEETH? _____

ANY PAIN IN OR NEAR THE EARS? YES ☐ NO ☐
☐ RIGHT LEFT ☐

ANY CLICKING OR DISCOMFORT OF THE JAW JOINT NEAR EARS? YES ☐ NO ☐
☐ RIGHT LEFT ☐

DOES PATIENT DESIRE TREATMENT? YES ☐ NO ☐

IN YOUR OWN WORDS WHAT WOULD YOU LIKE US TO ACCOMPLISH FOR YOU?
_____
_____

OTHER RELEVANT INFORMATION: _____
_____
_____
_____
_____
_____

_____ _____
SIGNATURE DATE