PATIENT INFORMATION (please print)

Name_____home number_____Cell_____
Address_____city_____state_____Zip_____
Birthdate_____age_____social security#_____Marital Status: S/M/W/D
Employer_____Work Phone_____
Employer Address_____Occupation_____
If full time student, school name and address_____
Email address_____referred by_____

SPOUSE / PARENT REPONSIBLE PARTY

Name_____home phone_____cell phone_____
Address_____city_____state_____zip_____
Birthdate_____age_____social security #_____relationship_____
Employer_____work phone_____
Employer address_____occupation_____

DENTAL INSURANCE

Insured's Name_____Relation_____
Insurance co_____Phone#_____
Identification #_____Group #_____

DENTAL HISTORY

Chief dental complaint_____
Last dental visit_____
Last full mouth xrays?_____
Do you require antibiotics before treatment? ○Y ○N
Are you currently in pain? ○Y ○N
Are you apprehensive about dental treatment? ○Y ○N
Have you ever had periodontal/gum treatment? ○Y ○N
Do your gums bleed, feel tender, irritated? ○Y ○N
Would you like your smile to look different? ○Y ○N
Have you ever had jaw problems? (eg. Clicking) ○Y ○N
Are your teeth sensitive? Hot /cold /sweets / pressure ○N
Do you have: ○ headaches ○ earaches ○ neck pain

MEDICAL HISTORY

Do you currently have any health problems ○**Yes** ○**No**
Are you currently under a physician's care ○**Yes** ○**No**
If yes, for what_____
_____
Medications you are currently taking_____
_____
_____
LIST ANY ALLERGIES_____
_____
_____

Do you have or had any of the following:

○High Blood Pressure	○Diabetes	○Radiation Treatments	○Psychiatric Treatment
○Heart Disease	○Smoker	○Cancer	○Drug/Alcohol Abuse
○Heart Attack (date_____)	○Liver/kidney Disease	○Artificial joints	○Chemotherapy
○Heart Surgery (date_____)	○Bruise easily	○Hepatitis A/B/C	○Pregnant/Nursing
○Heart Murmer	○Blood transfusion	○Aids/HIV	○Bleeding problems
○Angina pectoris	○Lung disease:_____	○Tuberculosis	○Stroke
○Mitral Valve Prolapse	○Seizures	○Sinus Problems	○Autoimmune Disease
○Prosthetic Heart Valve	○Fainting	○Allergies	○Any Other Disease/Condition
○Pacemaker	○Stomach Ulcers/ Colitis	○Glaucoma	-_____

*I certify that I have read and understand the above questions and have been accurately answered. I understand that providing incomplete or incorrect information can be dangerous to my health.
I authorize *the release of my records to any referring specialists or physician.(note: we will only do this if necessary for your treatment)

SIGNATURE_____DATE_____

I have read and understand HIPAA guidelines: _____

Dr Signature_____