PATIENT INFORMATION – GENERAL:

NAME: _____ DATE: _____

FIRST MI LAST

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH (MM/DD/YYYY): _____ SOCIAL SECURITY #: _____

PRIMARY PHONE #: _____ CELL ☐ HOME ☐ E-MAIL: _____

SECONDARY PHONE #: _____ CELL ☐ HOME ☐ DRIVER'S LICENSE #: _____

CHECK APPROPRIATE BOX: MINOR - ☐ SINGLE - ☐ MARRIED - ☐ DIVORCED - ☐ WIDOWED - ☐ SEPARATED - ☐

WHOM MAY WE THANK FOR REFERRING YOU? _____

EMERGENCY CONTACT:

NAME: _____ PHONE #: _____

FIRST LAST

RESPONSIBLE PARTY:

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: _____

*****IF PERSON RESPONSIBLE FOR THIS ACCOUNT IS THE PATIENT, AND ALL OF THE INFORMATION IS THE SAME AS ABOVE, PLEASE CHECK THIS BOX AND CONTINUE TO THE 'INSURANCE' SECTION OF THIS FORM:** ☐

RELATIONSHIP TO PATIENT: _____ ADDRESS: _____

PRIMARY PHONE #: _____ DRIVER'S LICENSE #: _____ STATE: _____

DOB (MM/DD/YYYY) _____ SOCIAL SECURITY #: _____

EMPLOYER: _____ WORK PHONE #: _____

IS THIS PERSON CURRENTLY A PATIENT AT OUR OFFICE? YES - ☐ NO - ☐

PRIMARY DENTAL INSURANCE INFORMATION:

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

DOB (MM/DD/YYYY): _____ SOCIAL SECURITY #: _____

NAME OF EMPLOYER: _____ DATE EMPLOYED: _____

UNION OR LOCAL #: _____ WORK PHONE #: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE COMPANY: _____ POLICY/ID #: _____ GROUP #: _____

INSURANCE COMPANY ADDRESS: _____ INSURANCE COMPANY PHONE #: _____

SECONDARY DENTAL INSURANCE INFORMATION *(IF APPLICABLE)*:

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

DOB (MM/DD/YYYY): _____ SOCIAL SECURITY #: _____

NAME OF EMPLOYER: _____ DATE EMPLOYED: _____

UNION OR LOCAL #: _____ WORK PHONE #: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE COMPANY: _____ POLICY/ID #: _____ GROUP #: _____

INSURANCE COMPANY ADDRESS: _____ INSURANCE COMPANY PHONE #: _____

X _____ DATE: _____

SIGNATURE OF PATIENT OR GUARDIAN IF MINOR

PATIENT MEDICAL HISTORY

PATIENT'S NAME:_____ **EMAIL:**_____ **DATE OF BIRTH**:_____

**ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

1. ARE YOU IN GOOD HEALTH……. YES NO
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR… YES NO
3. DATE OF YOUR LAST PHYSICAL EXAM_____
4. PHYSICIAN'S NAME _____
   ADDRESS_____
   PHONE NO. _____
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN…….. YES NO
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS…… YES NO
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE …… YES NO
   IF YES, WHAT MEDICATION(S)…
   _____
8. HAVE YOU HAD ANY ABNORMAL BLEEDING …… YES NO
9. DO YOU BRUISE EASILY ……. YES NO
10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION …….. YES NO
11. HAVE YOU HAD A RECENT WEIGHT LOSS ____ ____
12. HAVE YOU EVER TAKEN FEN-PHEN OR REDUX…… YES NO
13. DO YOU USE TOBACCO …… YES NO
14. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES …….. YES NO
15. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT… YES NO

WOMEN ONLY:

16. ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT …….. YES NO
17. ARE YOU NURSING …… YES NO
18. ARE YOU TAKING BIRTH CONTROL PILLS YES NO

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

LOCAL ANESTHETICS LIKE NOVOCAINE…….. YES NO
PENICILLIN OR OTHER ANTIBIOTICS…….. YES NO
SULFA DRUGS…… YES NO
BARBITURATES, SEDATIVES OR SLEEPING PILLS…… YES NO
ASPIRIN…… YES NO
ANY METALS (E.G., NICKEL, MERCURY, ETC.) …… YES NO
LATEX / RUBBER …… YES NO
Others (PLEASE LIST)
_____

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING?

DIABETES:	YES NO	HYPOGLYCEMIA:	YES NO
RHEUMATIC FEVER:	YES NO	THYROID PROBLEMS:	YES NO
SCARLET FEVER:	YES NO	ALLERGIES:	YES NO
HEART DEFFECT:	YES NO	JOINT REPLACEMENT:	YES NO
HEART MURMUR:	YES NO	KIDNEY TROUBLE:	YES NO
HEART TROUBLE:	YES NO	TUBERCULOSIS:	YES NO
HEART ATTACK:	YES NO	TUMORS:	YES NO
EPILEPSY OR SEIZURES:	YES NO	ANGINA:	YES NO
MENTAL HEALTH CARE:	YES NO	STROKE:	YES NO
PACEMAKER:	YES NO	CHEST PAIN:	YES NO
HEART SURGERY:	YES NO	SINUS TROUBLE:	YES NO
LIVER DISEASE:	YES NO	FEVER BLISTERS:	YES NO
HEPATITIS:	YES NO		
JAUNDICE:	YES NO		
COLD SORES:	YES NO		

SHORTNESS OF BREATH: YES NO
CONGENITAL HEART PROBLEM: YES NO
HIGH/LOW BLOOD PRESSURE: YES NO
EATING DISORDERS: YES NO
SEXUALLY TRANSMITTED DISEASE: YES NO
ASTHMA OR HAY FEVER: YES NO
CHEMICAL DEPENDENCY: YES NO
AIDS OR HIV INFECTION: YES NO
CORTISONE TREATMENT: YES NO
CHEMOTHERAPY(CANCER/LEUKEMIA): YES NO

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT FOR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHROIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR MY SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X_____ **DATE**_____

SIGNITURE OF PATIENT OR PARENT/GUARDIAN OF A MINOR