



Welcome to our office. Thank you for the confidence you place with us to provide your dental care. In order for us to best serve you, please complete the following form. This information will aid us in providing the best services to meet your dental needs. If any of this information changes at any point, please let us know. All info will be kept strictly confidential and not shared. If you have any questions, please don't hesitate to ask.

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_  
Last First MI

Home address: \_\_\_\_\_  
Street Apt City State Zip

Phone - Home: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner ☐

Social Security #: \_\_\_\_\_ Email: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ Driver's License State: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Is it okay for us to contact you through text messaging and email? Yes / No \_\_\_\_\_

Has any member of your family been treated in our practice? Yes / No If yes, name of patient: \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

**WHO SHOULD WE CONTACT IN CASE OF AN EMERGENCY?**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

**PRIMARY INSURANCE:** Name of subscriber: \_\_\_\_\_ Employer: \_\_\_\_\_

Name of insurance company: \_\_\_\_\_ Insurance ID # or SS # of subscriber: \_\_\_\_\_

Address of insurance company: \_\_\_\_\_

Phone # of insurance company: \_\_\_\_\_ Group #: \_\_\_\_\_ Birthday of subscriber: \_\_\_\_\_

**SECONDARY INSURANCE:** Name of subscriber: \_\_\_\_\_ Employer: \_\_\_\_\_

Name of insurance company: \_\_\_\_\_ Insurance ID # or SS # of subscriber: \_\_\_\_\_

Address of insurance company: \_\_\_\_\_

Phone # of insurance company: \_\_\_\_\_ Group #: \_\_\_\_\_ Birthday of subscriber: \_\_\_\_\_

**I certify that all the information above is correct to the best of my knowledge. I agree to notify this office of any changes to the above information as soon as reasonably possible.**

**Signature of patient (or legal guardian if minor):** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Health Information

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

What is your main dental concern for today's visit? \_\_\_\_\_

### Oral Health (Circle Yes or No)

1. Yes / No - Do you currently have any known dental problems?
2. Yes / No - Are any of your teeth sensitive to hot, cold, biting pressure, or sweets?
3. Yes / No - Do your gums bleed when brushing or flossing?
4. Yes / No - Have you ever been told you have periodontal (gum) disease?
5. Yes / No - Have you had a complete set of dental x-rays in the past year?
6. Yes / No - Do your jaw joints (TMJ) click, pop, or cause pain?
7. Yes / No - Do you clench or grind your teeth?
8. Yes / No - Have you had your wisdom teeth removed?
9. Yes / No - Do your teeth show signs of chipping and wear?
10. Yes / No - Do you have a replacement of any type for missing teeth?
11. Yes / No - Have you ever had any unfavorable dental experiences?
12. Yes / No - Is there anything you would like to change about your smile?

### Medical Health

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

1. Yes / No - Are you under the care of a physician now? If yes, reason(s) \_\_\_\_\_
2. Yes / No - Have you been hospitalized in the past 5 years? Why? \_\_\_\_\_
3. Yes / No - Have you had any serious illnesses or operations? \_\_\_\_\_
4. Yes / No - Are you currently taking any medications, pills, or drugs? Please list \_\_\_\_\_  
\_\_\_\_\_

5. Yes / No - Are you allergic to any medications or other substances? (Circle all that apply)

**Aspirin   Penicillin   Other Antibiotics   Codeine   Anesthetics   Metals   Latex   Other** \_\_\_\_\_

6. Do you have, or have you ever had, any of the following?

Yes / No - Angina	Yes / No - Stroke	Yes / No - STDs
Yes / No - Heart Attack	Yes / No - Diabetes	Yes / No - Kidney Disease
Yes / No - Heart Defect	Yes / No - Osteoporosis	Yes / No - Liver Disease
Yes / No - Artificial Heart Valve	Yes / No - Artificial Joints	Yes / No - Tuberculosis
Yes / No - Pacemaker	Yes / No - Cancer/Tumor	Yes / No - Fainting Spells
Yes / No - Any Other Heart Issues	Yes / No - Chemo/Radiation Therapy	Yes / No - Epilepsy/Seizures
Yes / No - High Blood Pressure	Yes / No - Excessive Bleeding	Yes / No - Thyroid Problems
Yes / No - Low Blood Pressure	Yes / No - AIDS/HIV	Yes / No - Psychiatric Problems
Yes / No - Rheumatic Fever	Yes / No - Hepatitis (A, B, C)	

7. Yes / No - Do you have any disease, conditions, or condition not listed above? Please List \_\_\_\_\_
8. Yes / No - Do you require antibiotic premedication for dental treatment?
9. **Women:** (Check if applicable)   ☐ Pregnant (Due Date)   ☐ Nursing   ☐ Taking Birth Control
10. Is there anything else you would like for us to know about? \_\_\_\_\_

**I certify that all the information above is true and correct to the best of my knowledge. I understand that an accurate medical and dental history is necessary to safely and completely treat my dental needs. I agree to let this office know as soon as possible if any of this information changes.**

\_\_\_\_\_  
Patient's Signature (or Parent/Guardian)

\_\_\_\_\_  
Date