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 clinch 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 Deffect	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