

## PATIENT INFORMATION

PATIENT'S NAME Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ SEX: M F BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_  
 Soc. Sec. # \_\_\_\_\_ If Patient is a Minor, give Parent's or Guardian's Name \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_  
 Who May We Thank for Referring You to our Office? \_\_\_\_\_ Reason for this Visit \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

NAME Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_  
 RESIDENCE Street \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 MAILING ADDRESS Street \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 HOW LONG AT THIS ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
 WORK PHONE \_\_\_\_\_ E-MAIL \_\_\_\_\_  
 PREVIOUS ADDRESS (if less than 3 yrs.) Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ How Long \_\_\_\_\_  
 SOCIAL SECURITY # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ NO. YEARS EMPLOYED \_\_\_\_\_

### RESPONSIBLE PARTY'S SPOUSE

NAME \_\_\_\_\_  
LAST FIRST MIDDLE  
 EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ ( )  
NO. YEARS EMPLOYED  
 SOC. SEC. # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
 HOME PH. \_\_\_\_\_ CELL PH. \_\_\_\_\_  
 WORK PH. \_\_\_\_\_ E-MAIL \_\_\_\_\_

### EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY, STATE \_\_\_\_\_  
 HOME PH. \_\_\_\_\_ CELL PH. \_\_\_\_\_  
 WORK PH. \_\_\_\_\_

### DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_ E-MAIL \_\_\_\_\_  
 Insurance Co. Address \_\_\_\_\_  
 Insured's Employer \_\_\_\_\_  
 Insured's Soc. Sec. # \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

### If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_ E-MAIL \_\_\_\_\_  
 Insurance Co. Address \_\_\_\_\_  
 Insured's Employer \_\_\_\_\_  
 Insured's Soc. Sec. # \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

**It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.**

*DENTAL HISTORY*		YES	NO	*MEDICAL HISTORY*		YES	NO					
HOW LONG SINCE you have seen a dentist?				Do you have any CURRENT HEALTH PROBLEMS?		<input type="checkbox"/>	<input type="checkbox"/>					
Last COMPLETE Dental Exam, Date:				Are you under a PHYSICIAN'S CARE now?		<input type="checkbox"/>	<input type="checkbox"/>					
Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic)				For what?								
Are you having PROBLEMS now?		<input type="checkbox"/>	<input type="checkbox"/>	What MEDICATIONS are you currently taking?								
WHAT?				Have you ever taken Fen-Phen/Redux?		<input type="checkbox"/>	<input type="checkbox"/>					
Is your present dental health POOR?		<input type="checkbox"/>	<input type="checkbox"/>	Have you ever used a BISPHOSPHONATE MEDICATION?		<input type="checkbox"/>	<input type="checkbox"/>					
Do you wear DENTURES? (Partials or Full)		<input type="checkbox"/>	<input type="checkbox"/>	<small>(Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva)</small>								
Are you UNHAPPY with your dentures?		<input type="checkbox"/>	<input type="checkbox"/>	Are you PREGNANT?		<input type="checkbox"/>	<input type="checkbox"/>					
Would you like to know more about PERMANENT REPLACEMENTS?		<input type="checkbox"/>	<input type="checkbox"/>	Do you use CIGARS/CIGARETTES, PIPE or CHEWING TOBACCO? (circle)		<input type="checkbox"/>	<input type="checkbox"/>					
Are you APPREHENSIVE about dental treatment?		<input type="checkbox"/>	<input type="checkbox"/>	PLEASE ✓ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:								
Have you had any PERIODONTAL (GUM) treatments?		<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV Pos.	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums BLEED, or feel TENDER or IRRITATED?		<input type="checkbox"/>	<input type="checkbox"/>	Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	Food allergies	<input type="checkbox"/>	<input type="checkbox"/>	Rapid weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)		<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>
Are you UNHAPPY with the APPEARANCE of your teeth?		<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (Rheumatism)	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of GRINDING or CLENCHING your teeth?		<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>
Do you have HEADACHES, EARACHES, or NECK PAINS?		<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems (please describe)	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Have you worn BRACES on your teeth (ORTHODONTICS)?		<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>				Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Do you have DISCOLORED teeth that bother you?		<input type="checkbox"/>	<input type="checkbox"/>	Atopic (Allergy Prone)	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia (Abnormal bleeding)	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>	<input type="checkbox"/>
Would you like your smile to LOOK BETTER or DIFFERENT?		<input type="checkbox"/>	<input type="checkbox"/>	Back problems	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>
Do you REGULARLY use DENTAL FLOSS?		<input type="checkbox"/>	<input type="checkbox"/>	Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Name of Previous Dentist:				Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Surgical implant	<input type="checkbox"/>	<input type="checkbox"/>
City: _____ State: _____				Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet or ankles	<input type="checkbox"/>	<input type="checkbox"/>
How do you feel about your teeth?				Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease or malfunction	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease or malfunction	<input type="checkbox"/>	<input type="checkbox"/>
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.				Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco habit	<input type="checkbox"/>	<input type="checkbox"/>
FEAR of pain # _____ LACK of concern # _____				Cortisone treatments	<input type="checkbox"/>	<input type="checkbox"/>	Material allergies	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
COST of treatment # _____ MISSING work time # _____				Cough (persistent)	<input type="checkbox"/>	<input type="checkbox"/>	(latex, wool, metal, chemicals)			Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
				Cough up blood	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer/Colitis	<input type="checkbox"/>	<input type="checkbox"/>
				Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Nervous problems	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
				Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker/heart surgery	<input type="checkbox"/>	<input type="checkbox"/>			
				ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?								
				Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetic	<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>
				Nitrous Oxide	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
				Are you aware of being allergic to any other medications or substances?								
				If yes, please list:								
				Is there any other Medical or Dental information that you feel I should know about?								
				FAMILY PHYSICIAN		PHONE		E-MAIL				