

PATIENT INFORMATION

PATIENT NAME _____ HOW DO YOU PREFER TO BE ADDRESSED? _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____ HOME PHONE _____

ADDRESS _____
(street) (city) (state) (zip)

EMPLOYER _____ BUSINESS PHONE _____

INSURED PARTY'S NAME _____

INSURED PARTY'S EMPLOYER _____

RELATIONSHIP TO PATIENT (self) _____ (spouse) _____ (child) _____ (other) _____

INSURANCE COMPANY NAME _____

ADDRESS _____
(street) (city) (state) (zip)

PHONE NUMBER (_____) _____ GROUP/IDENTIFICATION NUMBER _____
("800" number preferred)

INSURED PARTY'S BIRTHDATE _____ INSURED SOCIAL SECURITY NUMBER _____

(If you have secondary insurance coverage, please see the front desk for another form)

1. How often do you visit your dentist? _____

2. When and why was your last visit? _____

3. Have you ever had previous Periodontal Treatment? Y N (If yes, what and when?)

4. Have you had Orthodontic Treatment? Y N (If yes, what and where?)

5. Are you satisfied with the appearance of your teeth? Y N (If no, why not?)

6. Have your teeth shifted in recent years? Y N (If yes, which ones?) _____

7. Do you grind/clench your teeth? Y N _____

8. Oral Hygiene habits: Brush _____ Floss _____ Mouthwash _____ Other _____

9. When did you find out you might have a gum problem? _____

10. Any family history of gum disease? Y N _____

DENTAL-MEDICAL HISTORY

1. Have you been a patient in the hospital during the past 2 years? Y N
2. Have you been under a physician's care during the past 2 years? Y N
3. How long has it been since you were last seen by a physician?
4. Have you had rheumatic fever or rheumatic heart disease? Y N
5. Do you have a heart murmur or mitral valve prolapse? Y N
6. Circle any of the following which you have/had:

heart trouble	thyroid disease	congestive heart failure	high blood pressure
heart attack	cancer	congenital heart lesions	psychiatric treatment
tuberculosis	sinus trouble	diabetes (high blood sugar)	frequent headaches
glaucoma	kidney disease	heart murmur (leaky valve)	cough (persistent)
arthritis	lung disease	angina (chest pains)	joint replacement
stroke (CVA)	asthma/allergy	anemia or blood disorder	hepatitis/liver disease
AIDS	stomach disorder	epilepsy/seizure disorder	drug/alcohol abuse
7. Have you had any disease, condition or problem not listed above? Y N
If yes, what? _____
8. Have you had excessive bleeding after a cut, extraction or other injury? Y N
9. Have you had an allergic or unusual reaction to any drugs, medications local or general anesthetic? Y N
If yes, what? _____
10. Do you smoke? Y N
11. Please list any medications you are presently taking:

Name	Amount	Reason
_____	_____	_____
_____	_____	_____
12. Are you pregnant or nursing at the present time? Y N
13. Please list the name, phone number and address of your physician.

14. Have you had trouble with previous dental treatment? Y N
15. Do you wish to keep your teeth as long as possible? Y N
16. Who may we contact in case of an emergency? _____
(name) (phone)

To my knowledge, the above information is correct and complete.

Signature

Date