Patient Information

Date_____

Patient's Name_____ _____ _____
Last First Middle Male Female

_____
Street

_____ Home Phone _____
City State Zip

Birthdate _____ Cell Phone _____

Social Security #_____ Driver's License #_____

Employer_____ Occupation _____

Employer's Address_____ Phone # _____

If patient is a minor, give parent's or guardian's name _____

Patient's Dentist_____ Email Address _____

Whom may we thank for referring you to our office? _____

Responsible Party Information (Legal Custody If Patient Is A Child)

Name_____ _____
Last First Middle Marital Status

Address_____ How long at this address _____
Street

_____ Home Phone _____
City State Zip

Work Phone _____

Cell Phone _____

Previous Address _____
Street

_____ How Long At This Address _____
City State Zip

Relationship to Patient _____

Social Security #_____ Birthdate _____

Employer_____ Occupation _____

Employer's Address_____ No. Years Employed _____

Driver's License #_____ State _____

Spouse's Name _____
Last First Middle

Spouse's Employer_____ Address _____

Occupation_____ No. Years Employed_____ Work Phone _____

Spouse's Social Security #_____ Spouse's Birthday_____

Spouse's Driver's License # _____ State _____ Cell Phone _____

Insurance Information

PRIMARY INSURANCE Insured's Name _____

Social Security #_____

Insurance Company _____ Phone #_____

SECONDARY INSURANCE Insured's Name _____

Social Security #_____

Insurance Company _____ Phone #_____

Emergency Information

Name of nearest relative/friend not living with you_____ Relationship _____

Complete Address_____

_____ Phone _____

I understand that when appropriate, credit bureau reports may be obtained.

Signature (Parent's signature of minor)_____

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SIBLINGS

Please provide name and birthdate of any siblings living in the same home.

Name _____ D.O.B. _____ Name _____ D.O.B. _____

Name _____ D.O.B. _____ Name _____ D.O.B. _____

MEDICAL HISTORY

Bone disease, heart trouble, TB, diabetes, kidney or liver involvements, epilepsy, rheumatic fever, hemophilia or any other major illness? _____

Any history of ear aches or repeated middle ear infections? _____

Have adenoids or tonsils been examined or removed? _____

Are there any allergies to medicines, foods, plants, etc.? If so, _____

Have you ever had asthma, hay fever, skin rashes, stuffy nose repeatedly? _____

Present medications? _____

Are you under care of a physician now? _____

Have any medical x-rays been taken in the past six months? _____

Have you ever had a metabolic or endocrine imbalance? _____

Have you ever had any nervous conditions? _____

Any other health problems not mentioned? _____

DENTAL HISTORY

Cavities? _____

Extractions? _____

Bleeding gums? _____

Teeth injured or broken? _____

Are lips often kept apart when at rest? _____

Is much breathing done through the mouth? _____

Have you ever noticed any speech problems? _____

Have there ever been any habits which might have caused the teeth to move such as thumb sucking, chewing on finger nails, lips, cheeks, tongue? _____

Do you have pain when chewing? _____

Do you play a musical instrument with a mouthpiece? _____

Does your mouth have any inherited characteristics? _____

Dental health of other family members? (regular visits) _____

Any friends or relatives treated here? _____

How long since you were cared for by a dentist? and had x-rays? _____

SUBMIT