

**Patient Information**

Patient Name: \_\_ Sex: F/M Date of Birth: \_\_\_/\_\_\_/\_\_\_ SSN:

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

Home Address: \_\_\_\_City/State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_

**Financial Responsibility**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber I.D \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health History**

Has there been a change in your health in the last year?........................................................................................ Yes No

Are you being treated by a physician now? ……………………………………………………………………………………………………… Yes No

  *If yes, why?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last medical exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last dental exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had problems with prior dental treatment?............................................................................................. Yes No

 *If yes, explain*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you in pain now?................................................................................................................................................ Yes No

Do you have any **ALLERGIES**?................................................................................................................................... Yes No

 If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Women only:** Are you or could you be pregnant or breastfeeding?....................................................................... Yes No

**Do you have or have you had:**

* Heart disease
* Cancer/chemo
* Rheumatic Fever
* Stroke/Hardening of Arteries
* Aids or HIV
* Pacemaker
* Eye disease
* Thyroid, Adrenal Disease
* Diabetes
* High blood Pressure
* Venereal Disease
* Sickle Cell Disease
* Anemia
* Epilepsy/Seizures
* Skin Disease
* Kidney, Bladder Disease
* Asthma
* Arthritis
* Eye Disease
* Stomach Problems/Ulcers
* Hepatitis/Liver Disease
* Hemophilia
* Artificial Joints
* Other:\_\_\_\_\_\_\_\_\_\_\_\_

**Are you taking:**

Tobacco in any form? ........................................... Yes No Recreational drugs? ................................. Yes No

Drugs, medications? ............................................. Yes No Alcohol? .................................................... Yes No

Over-the-counter medicines (inc. aspirin), natural remedies? ................................................................................ Yes No

  *Please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**ALL patients:** Do you have/have you had ANY condition or medical problem NOT listed on this form? ………....... Yes No

 If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?**

Sign :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Friend/Relative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee/Representative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance:\_\_\_\_\_\_\_\_\_\_\_\_ Poster:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other where?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have answered every question completely and accurately to the best of my knowledge. I will inform my dentist of any change in my health and/or medication.

Patient/Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_