Patient Information Form

Patient's Name: _____ Preferred Name: _____
DOB: _____

____Mr. ____Mrs. ___Ms. ___Dr. ___Rev. SEX M / F Other

Address_____ Apt/Suite # _____

City _____ State _____ Zip_____

Cell Phone _____ Home Phone _____

Email Address _____

Emergency Contact _____ Phone Number _____

Employer/Occupation _____ Employer Phone _____

**If patient is a child fill out the next part*

Responsible person _____ Relationship to Patient _____

DOB: _____ Social Security_____ Sex: M / F

Cell# _____ Home#_____

Address (if different from top) _____ Apt/Suite # _____

City _____ State _____ Zip_____

Insurance Information (Cross out if no insurance)

Insurance name (Primary) _____

Primary Subscriber _____ Subscriber DOB _____

ID# _____ Group # _____

Insurance name (Secondary) _____

Secondary Subscriber _____ Subscriber DOB _____

ID# _____ Group # _____

Dental History

Reason for Today's Visit _____
Date of last X-rays _____ Date of last dental visit _____
Dentist Name: _____

(This information is necessary for our files and will be considered CONFIDENTIAL)

Check if you have had problems with any of the following:

___ Bad Breath ___ Grinding teeth ___ Sensitivity to hot/cold

___ Bleeding gums ___ Loose teeth ___ Sensitivity to sweets

___ Clicking or popping jaw ___ Broken fillings ___ Sores or growths in mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Are you in good health? Y N Date of last physical examination _____

Are you being treated by a physician? Y N If yes, for what? _____

Have you had history of serious illness or operation? Y N If yes, for what? _____

Have you been hospitalized? Y N If yes, for what? _____

Tobacco Use? Y N If yes, for how long and how often? _____

Are you currently taking any medication? _____

Are you taking any recreational drugs? _____

Have you ever been pre-medicated with antibiotics for your dental treatment? Y N

Any allergies to medication? _____

(Women) Are you pregnant? __ Yes __ No Nursing? __ Yes __ No Birth Control Pills? __ Yes __No

Check if you have or have had any of the following:

Y N Anemia	Y N Glaucoma	Y N Sleep Apnea	Y N Angina Pectoris	Y N Pain in Jaw Joints	Y N Psychiatric Treatment
Y N Herpes	Y N Tonsillitis	Y N Snoring	Y N Mental Disorder	Y N Artificial Prosthesis	Y N Hepatitis or Jaundice
Y N Stroke	Y N Hemophilia	Y N Heart Murmur	Y N Thyroid Disease	Y N Sickle Cell Disease	Y N Difficulty Swallowing
Y N Ulcer	Y N Cold Sores	Y N Liver Disease	Y N Fainting Spells	Y N Cortisone Medicine	Y N Congenital Heart Lesions
Y N Diabetes	Y N Emphysema	Y N Blood Disease	Y N Rheumatic Fever	Y N Allergies to Metals	Y N Osteoporosis
Y N Arthritis	Y N Rheumatism	Y N Heart Ailments	Y N Tuberculosis (T.B.)	Y N Excessive Bleeding	Y N X-Ray or Cobalt Treatment
Y N Asthma	Y N Chicken Pox	Y N Heart Attack	Y N Blood Transfusion	Y N Mitral Valve Prolapse	Y N Radiation Treatment
Y N Cancer	Y N Bruise Easily	Y N Cerebral Palsy	Y N Low Blood Sugar	Y N High Blood Pressure	Y N Venereal Disease
Y N Seizures	Y N Head Injuries	Y N Drug Addiction	Y N Joint Replacement	Y N Low Blood Pressure	Y N AIDS
Y N Hay Fever	Y N Heart Failure	Y N Kidney Disease	Y N Nervous Disorders	Y N HIV Related Complex	Y N TMJ Disorder
Y N Headaches	Y N Scarlet Fever	Y N Chemotherapy	Y N Tumors or Growths	Y N Respiratory Disease	
Y N Implant(s)	Y N Sinus Trouble	Y N Stomach Ulcers	Y N Allergies or Hives	Y N Epilepsy or Seizures	

Do you have any disease, conditions, or problem not listed that you think we should know about? Y N
If so, what? _____
Do you wear a cardiac pacemaker, or have you had a heart surgery? Y N

Patient/Guardian Signature _____ Date _____

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