PATIENT INFORMATION:

Today's Date _____

Name _____ DOB _____ Age _____
First MI Last

Address _____ Male / Female

City _____ State _____ Zip _____

Home# _____ E-Mail _____

Work# _____ Ext._____ Cell# _____

General Dentist _____ Last cleaning visit _____

Address _____ Phone# _____

Other relatives seen by us: _____

Who may we thank for referring you? _____

ADDITIONAL INFORMATION:

Employer _____ Address _____

Occupation _____ How long have you worked there? _____

When and where are the best times to reach you? _____

Spouse's Name _____

Employer _____ Work# _____Ext:_____

Who is financially responsible for this account? _____ Relation _____

Address (if other than patient) _____ Phone# _____

INSURANCE INFORMATION: Do you have Orthodontic coverage **Y** / **N** If yes, complete the following:

PRIMARY CARRIER _____ Address _____

Phone# _____ Group# _____ ID# / SS# _____

Insured's Name _____ DOB _____ Relationship to Patient _____

Employer _____ Phone# _____

SECONDARY CARRIER _____ Address _____

Phone# _____ Group# _____ ID# / SS# _____

Insured's Name _____ DOB _____ Relationship to Patient _____

Employer _____ Phone# _____

HEALTH HISTORY

Y / N Have you ever had a serious/difficult problem associated with dental work?
Y / N Do you like your smile?
Y / N Do your gums ever bleed?
Y / N Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)?
Y / N Do you brush your teeth daily? If yes, how often? _____
Y / N Do you floss your teeth? If yes, how often? _____

Personal Physician _____ Phone# _____ Last Visit_____

Please describe your current physical health: GOOD FAIR POOR

Are you currently under the care of a physician? **Y / N** If yes, please explain _____

FOR WOMEN ONLY:
Y / N Are you taking birth control?
Y / N Are you pregnant?
Y / N Are you nursing

Have you ever had any of the following medical problems?

Y / N Prothesis
Y / N Heart Attack
Y / N Diabetes
Y / N Rheumatic Fever
Y / N HIV+ / AIDS
Y / N Hemophilia
Y / N Asthma
Y / N Hepatitus
Y / N Tuberculosis
Y / N Shingles
Y / N Emphysema
Y / N Difficulty Breathing?

Y / N Congenital Heart Defect
Y / N Convulsions / Epilepsy
Y / N Abnormal Bleeding
Y / N Heart Murmur
Y / N Mitral Valve Prolapse
Y / N Any Stays in Hospital
Y / N Kidney / Liver Problems
Y / N Drug/Alcohol Abuse
Y / N Fever Blister
Y / N Blood Transfusion
Y / N Glaucoma
Y / N Other:

Y / N History Of Scarlet Fever
Y / N Cancer
Y / N Artificial Valves
Y / N Heart Surg./Pacemaker
Y / N Artificial Bones/Joints
Y / N Sev./Freq. Headaches
Y / N Hi/Lo Blood Pressure
Y / N Veneral Disease
Y / N Ulcers/Colitis
Y / N Anemia/Radiation Tx
Y / N Sinus Problems

Are you allergic to any of the following?

Y / N Aspirin
Y / N Penicillin
Y / N Codeine
Y / N Erythromycin
Y / N Tetracycline
Y / N Dental Anesthetics
Y / N Latex

Please list any medication you are currently taking: _____

Please list all medications you are allergic to: _____

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need.

_____
Signature Date

FOR OFFICIAL USE ONLY

I have reviewed the medical / dental information above.

Initials:_____ Date: _____ Dr. Comments: _____