



Date _____

PATIENT INFORMATION

Mr. Mrs. Ms. Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____

Sex: Male Female Birth Date _____ Age _____ S.S. # _____ E-mail _____

Street _____ City _____ State _____ Zip _____

Home Tel. (_____) _____ Cell. (_____) _____ Have you ever been a patient of our practice? Yes No

Dentist _____ Medical Doctor _____ Referred By _____
FIRST NAME LAST NAME FIRST NAME LAST NAME FIRST NAME LAST NAME

Driver's Lic.# _____ Nearest relative not living with you _____ Tel. (_____) _____
FIRST NAME LAST NAME

Employer _____ Bus. Tel. (_____) _____ Personal Payment Type: Cash Check Credit Card

Who will be responsible for your account?

(If self, skip to next section)

Self Spouse Father Mother Other _____

Name _____ S.S.# _____ Birth Date _____ Age _____ Tel. (_____) _____
FIRST NAME LAST NAME

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel. (_____) _____

Spouse or other guarantor information (if different from above)

Name _____ Relation _____ S.S.# _____ Birth Date _____
FIRST NAME LAST NAME

Street _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel. (_____) _____

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PRIMARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____ CITY _____ STATE _____ ZIP _____
ADDRESS

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____
ADDRESS

CITY _____ STATE _____ ZIP _____ Tel. (_____) _____

Group # _____ Group Name _____

Insured Party _____ Relation _____
FIRST NAME LAST NAME

Sex: M F Birth Date _____

Address _____

CITY _____ STATE _____ ZIP _____

Tel. (_____) _____ S.S. # _____

I.D. # _____

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SECONDARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____ CITY _____ STATE _____ ZIP _____
ADDRESS

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____
ADDRESS

CITY _____ STATE _____ ZIP _____ Tel. (_____) _____

Group # _____ Group Name _____

Insured Party _____ Relation _____
FIRST NAME LAST NAME

Sex: M F Birth Date _____

Address _____

CITY _____ STATE _____ ZIP _____

Tel. (_____) _____ S.S. # _____

I.D. # _____



NAME _____ AGE _____ M F PATIENT # _____
FIRST LAST SEX SOCIAL SECURITY #

DENTAL HISTORY

Referring Dentist _____ City _____
FIRST NAME LAST NAME

Briefly describe your problem: _____

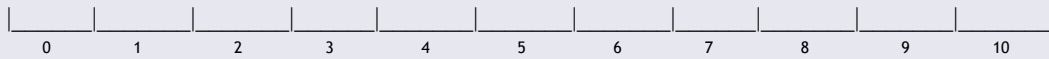
How long have you had this problem? _____ Day(s) _____ Week(s) _____ Month(s) _____ Year(s)

Check (X) all that apply:

PAIN: Never (If checked, go to SWELLING) **LOCATION :** Upper Left Upper Right Upper Front
 In the Past Today Lower Left Lower Right Lower Front

DURATION: Seconds Minutes Hours Constant **QUALITY:** Dull pain Throbbing pain Sharp pain

PAIN SCALE (check (X) 0-10): *Mild* _____ *Severe* _____



PROVOKED BY: Cold Hot Biting Sweet Spontaneous (unprovoked) Other _____

SWELLING: None In the Past Today **Today's Anxiety Level: (0-10)** _____

HEALTH HISTORY

Physician's Name _____ City _____ Date of last visit _____
FIRST NAME LAST NAME

1. Have you ever taken any of the group of drugs referred to as "fen-phen?" Yes No
2. Have you ever taken any of the group of drugs referred to as "bisphosphonates?" (fosamax, actonel, aredia, zometa, etc)
3. Have you been hospitalized or had a serious illness within the past 5 years? _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? CHECK YES (Y) or NO (N):

- | | | |
|---|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Y/N AIDS/HIV | <input type="checkbox"/> <input type="checkbox"/> Y/N Diabetes (type _____) | <input type="checkbox"/> <input type="checkbox"/> Y/N Respiratory / Breathing Problems |
| <input type="checkbox"/> <input type="checkbox"/> Y/N Anemia (type _____) | <input type="checkbox"/> <input type="checkbox"/> Y/N Ear (Cochlear) Implant | <input type="checkbox"/> <input type="checkbox"/> Y/N Rheumatic Fever |
| <input type="checkbox"/> <input type="checkbox"/> Y/N Arthritis, Rheumatism | <input type="checkbox"/> <input type="checkbox"/> Y/N Emphysema | <input type="checkbox"/> <input type="checkbox"/> Y/N Sinus Trouble |
| <input type="checkbox"/> <input type="checkbox"/> Y/N Artificial Heart Valve (Year _____) | <input type="checkbox"/> <input type="checkbox"/> Y/N Epilepsy or Seizures | <input type="checkbox"/> <input type="checkbox"/> Y/N Steroid Treatment |
| <input type="checkbox"/> <input type="checkbox"/> Y/N Artificial Joints (Year _____) | <input type="checkbox"/> <input type="checkbox"/> Y/N Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Y/N Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Y/N Asthma | <input type="checkbox"/> <input type="checkbox"/> Y/N Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Y/N Thyroid Problems |
| <input type="checkbox"/> <input type="checkbox"/> Y/N Back / Neck Problems | <input type="checkbox"/> <input type="checkbox"/> Y/N Heart Disease / Heart Surgery | <input type="checkbox"/> <input type="checkbox"/> Y/N Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Y/N Bleeding Abnormality | <input type="checkbox"/> <input type="checkbox"/> Y/N Hepatitis (type _____) | <input type="checkbox"/> <input type="checkbox"/> Y/N Tumor or Growth |
| <input type="checkbox"/> <input type="checkbox"/> Y/N Blood Disease | <input type="checkbox"/> <input type="checkbox"/> Y/N High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Y/N Ulcer |
| <input type="checkbox"/> <input type="checkbox"/> Y/N Cancer | <input type="checkbox"/> <input type="checkbox"/> Y/N Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> Y/N Venereal Disease |
| <input type="checkbox"/> <input type="checkbox"/> Y/N Chemical Dependency | <input type="checkbox"/> <input type="checkbox"/> Y/N Liver Disease | <input type="checkbox"/> <input type="checkbox"/> Y/N Other _____ |
| <input type="checkbox"/> <input type="checkbox"/> Y/N Chemotherapy | <input type="checkbox"/> <input type="checkbox"/> Y/N Pacemaker | |
| <input type="checkbox"/> <input type="checkbox"/> Y/N Congenital Heart Condition | <input type="checkbox"/> <input type="checkbox"/> Y/N Psychiatric Care | |
| <input type="checkbox"/> <input type="checkbox"/> Y/N Cough, persistent or bloody | <input type="checkbox"/> <input type="checkbox"/> Y/N Radiation Treatment | |

FEMALES ONLY: Are you Pregnant? Y/N Due Date _____
Are you Nursing?
Are you taking Birth Control Pills?

Current MEDICATIONS _____

ALLERGIES Aspirin or NSAIDs Local Anesthetic Latex Penicillin (or other antibiotics)
 Codeine Sulfa Drugs Iodine Other _____

I have answered above completely and accurately.

Signature (patient or parent/guardian) _____ **DATE** _____

Doctor signature _____ Date _____ BP _____ / _____ Review/date _____ / _____