PATIENT INFORMATION

NAME:..... DATE OF BIRTH:.....
HOME PHONE:..... ADDRESS:.....
CITY:..... STATE/ PROV.:.....
ZIP/ P.C.:..... E-MAIL:.....
CELL PHONE:.....
CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S or PARENT/
GUARDIAN'S NAME:..... WORK PHONE:.....
BUSINESS ADDRESS:..... CITY:.....
STATE/ PROV.:..... ZIP/ P.C.:.....
SPOUSE or PARENT/
GUARDIAN'S NAME:..... EMPLOYER:.....

WORK PHONE:.....
IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE:.....
CITY:..... STATE/ PROV.:.....
WHOM MAY WE THANK FOR REFERRING YOU? .....
PERSON TO CONTACT IN CASE OF AN EMERGENCY:.....
PHONE:.....

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT:.....
RELATIONSHIP TO PATIENT:.....
ADDRESS:..... HOME PHONE:.....
E-MAIL:..... CELL PHONE:.....
DRIVER'S LICENSE: #..... DATE OF BIRTH:.....
FINANCIAL INSTITUTION:..... EMPLOYER:.....
WORK PHONE:.....
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

INSURANCE ID: #..... NAME OF INSURED:.....
RELATIONSHIP TO PATIENT:..... BIRTHDATE:.....
SS #/SIN:..... DATE EMPLOYED:.....
NAME OF EMPLOYER:..... WORK PHONE:.....
ADDRESS OF EMPLOYER:..... CITY:.....
STATE/ PROV.:..... ZIP/ P.C.:.....
INSURANCE COMPANY:..... GROUP: #.....
UNION OR LOCAL: #..... INS. CO. ADDRESS:.....
CITY:..... STATE/ PROV.:.....
ZIP/ P.C.:.....

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING

NAME OF INSURED:..... RELATIONSHIP TO PATIENT:.....
BIRTHDATE:..... SS #/SIN:.....
DATE EMPLOYED:..... NAME OF EMPLOER:.....
WORK PHONE:..... ADDRESS OF EMPLOYER:.....
CITY:..... STATE/ PROV.:.....
ZIP/ P.C.:..... INSURANCE COMPANY:.....
GROUP: #..... UNION OR LOCAL: #.....
INS. CO. ADDRESS:..... CITY:.....
STATE/ PROV.:..... ZIP/ P.C.:.....

I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED OF MY BEHALF OR MY DEPENDENTS BEHALF. I UNDERSTAND THAT ANY BALANCE OVERDUE PAST 90 DAYS WILL BE REFERRED TO A COLLECTION AGENCY AND THAT I MAY BE LIABLE FOR ANY FEES INCURRED IN COLLECTING THE DELIQUENT BALANCE.

X.....

PATIENT NAME:..... TODAY'S DATE:.....
HOME DATE OF BIRTH:.....
ADDRESS:..... HOME PHONE:.....
E-MAIL:..... CELL PHONE:.....
BUSINESS BUSINESS PHONE:.....
ADDRESS:..... SS #/SIN:.....

PATIENT MEDICAL HISTORY

PHYSICIAN:..... OFFICE PHONE:.....
DATE OF LAST EXAM:.....

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATION(S) ARE YOU TAKING		
4. DO YOU USE TOBACCO?	☐	☐
5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	☐	☐
6. DO YOU WEAR CONTACT LENSES?	☐	☐
7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO MEDICATIONS?.....		
8. DO YOU TAKE MEDICATIONS FOR BONE DENSITY?	☐	☐

II. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
HIGH BLOOD PRESSURE	☐	☐	CARDIAC PACEMAKER	☐	☐	CANCER	☐	☐
HEART ATTACK	☐	☐	HEART MURMUR	☐	☐	CHEST PAINS	☐	☐
RHEUMATIC FEVER	☐	☐	ANGINA	☐	☐	EASILY WINDED	☐	☐
SWOLLEN ANKLES	☐	☐	FREQUENTLY TIRED	☐	☐	STROKE	☐	☐
FAINTING/ SEIZURES	☐	☐	ANEMIA	☐	☐	HAY FEVER/ ALLERGIES	☐	☐
ASTHMA	☐	☐	EMPHYSEMA	☐	☐	TUBERCULOSIS	☐	☐
LOW BLOOD PRESSURE	☐	☐	ARTHRITIS	☐	☐	RADIATION THERAPY	☐	☐
EPILEPSY/ CONVULSIONS	☐	☐	JOINT REPLACEMENT			GLAUCOMA	☐	☐
LEUKEMIA	☐	☐	OR IMPLANT	☐	☐	RECENT WEIGHT LOSS	☐	☐
DIABETES	☐	☐	HEPATITIS/ JAUNDICE	☐	☐	LIVER DISEASE	☐	☐
KIDNEY DISEASES	☐	☐	SEXUALLY TRANSMITTED			HEART TROUBLE	☐	☐
AIDS OR HIV INFECTION	☐	☐	DISEASE	☐	☐	RESPIRATORY PROBLEMS	☐	☐
THYROID PROBLEM	☐	☐	STOMACH TROUBLES/			OSTEOPOROSIS	☐	☐
HEART DISEASE	☐	☐	ULCERS	☐	☐	OTHER.....	☐	☐
BLOOD DISORDERS	☐	☐						

PATIENT DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/ FOODS?	☐	☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/ FOODS?	☐	☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐	☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?	☐	☐
A) CLICKING?	☐	☐
B) PAIN (JOINT, EAR, SIDE OF FACE)?	☐	☐
C) DIFFICULTY IN OPENING OR CLOSING?	☐	☐
D) DIFFICULTY IN CHEWING?	☐	☐
8. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
12. HAVE YOU HAD ANY ORTHODONTIC WORK?	☐	☐
13. HAVE YOU EVER HAD PROLOGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
14. HAVE YOU EVER HAD INSTRUCTIONS ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	☐	☐
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	☐	☐

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

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PATIENT, PARENT OR GUARDIAN DATE