

Patient Information

Date _____

Patient's Name _____
LAST FIRST MIDDLE PREFERS TO BE CALLED

Address _____
STREET CITY STATE ZIP

Home Phone _____ Age _____ Birthdate _____ Adult Patient SSN # _____

Cell Phone _____ Cell Provider _____ Email Address _____
(for text confirmation)

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Friends or relatives treated here _____

Patient's School _____

Responsible Party Information

Name _____
LAST FIRST MIDDLE PREFERS TO BE CALLED MARITAL STATUS

Residence _____
STREET CITY STATE ZIP

Mailing Address _____
STREET CITY STATE ZIP

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
STREET CITY STATE ZIP

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
LAST FIRST MIDDLE

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Dental Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Phone No. _____

Insurance Co. Address _____

Do you have dual coverage No Yes If yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group No. _____ Phone No. _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Emergency Contact _____

Complete Address _____

Phone _____

I understand that where appropriate, credit bureau reports may be obtained:

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

MEDICAL HISTORY

HAS THE PATIENT EVER BEEN TREATED FOR ANY OF THE FOLLOWING

	YES	NO		YES	NO		YES	NO
<i>DIABETES</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>RHEUMATIC FEVER</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>ENDOCRINE OR THYROID</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>PNEUMONIA</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>HEART MURMURS</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>PROLONGED BLEEDING</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>HEART TROUBLE</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>ANY CONDITION REQUIRING</i>			<i>HEPATITIS</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>TUBERCULOSIS</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>ANTIBIOTICS BEFORE DENTAL</i>			<i>VENEREAL DISEASE</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>BONE DISORDERS</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>PROCEDURES</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>AIDS OR HIV POSITIVE</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>EPILEPSY</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>WOMEN: ARE YOU PREGNANT</i>	<input type="checkbox"/>	<input type="checkbox"/>			

YES NO

IS THE PATIENT IN GOOD HEALTH? _____

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN, AND FOR WHAT CONDITION _____

LIST ANY OTHER SERIOUS ILLNESS (PHYSICAL OR MENTAL) _____

LIST ANY ALLERGIES OR DRUG SENSITIVITY _____

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE? _____

PATIENT'S PHYSICIAN _____ LAST SEEN _____

DENTAL HISTORY

YES NO

HAS THE PATIENT HAD ORTHODONTIC TREATMENT (BRACES)? HAPPY OR UNHAPPY WITH RESULT?

HAS THE PATIENT HAD PERIODONTAL (GUM) TREATMENT? DESCRIBE TREATMENT _____

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? _____

HAS THE PATIENT EVER SUCKED A THUMB OR FINGER? UNTIL WHAT AGE?? _____

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? _____

HAS THE PATIENT HAD ANY PREVIOUS ORTHODONTIC EXAMINATIONS? _____

DOES THE PATIENT CLENCH OR GRIND HIS/HER TEETH? _____

IS THE PATIENT ESPECIALLY APPREHENSIVE TOWARD DENTAL VISITS? _____

PATIENT'S DENTIST _____ LAST SEEN _____

DENTIST'S ADDRESS AND PHONE NUMBER _____

WHAT IS YOUR CHIEF CONCERN OR REASON FOR COMING TO OUR OFFICE? _____

LIST SPORTS AND INTERESTS _____
