About You

Today's Date: _____/_____/_____

Name:____
LAST FIRST MI

Preferred Name:____________________Marital Status: S M D W

Birthdate:_____/_____/_____ Age:_____ SSN:__________________

Address:____

____
CITY STATE ZIP

Email:____

Driver's License______________________ SS#___________________

Employer:____

How long there?:________ Occupation:________________________

Home Phone:_________________________ Cell:__________________

Work Phone:__________________________

Whom may we thank for referring you?:

____

In the event of an emergency, whom would you like us to contact?

His/Her Name:____

Relation: ____

Home Phone:_______________________ Cell:____________________

Dental Insurance Information

Insurance Co. Name: ______________________________

Insurance Co. Address: ____________________________

Insurance Co. Phone : _____________________________

Insured's ID #: ___________________________________

Group #: ____

Insured's Name: ___________________________________

Insured's SS#: ____________________________________

Insured's Birthdate: _____/_____/_____

Secondary Dental Insurance

Insurance Co. Name: ______________________________

Insurance Co. Address: ____________________________

Insurance Co. Phone: ______________________________

Insured's ID #: ___________________________________

Group #: ____

Insured's Name: ___________________________________

Insured's SS#: ____________________________________

Insured's Birthdate: _____/_____/_____

Spouse Information

His/Her Name: ____________________________________

Employer: _______________________________________

Work Phone:________________Cell:__________________

Birthdate: _____/_____/_____

(PLEASE COMPLETE BACK OF FORM)

Dental and Medical History

Previous General Dentist:_________________________ Last Visit:_________________________

What are the main concerns that you would like our office to accomplish?:_________________________

Are you currently in pain? Y / N Please specify: _________________________ Any pain in your jaw joint? Y / N

Have you experienced any unfavorable reaction from any previous dental care? Y / N Please specify: _________________________

Do you require antibiotics before dental procedures? Y / N If yes, please specify reason: _________________________

Family Physician:_________________________ Phone: _________________________

Address:_________________________

Your current physical health is: Good / Fair / Poor

Are you currently under a physician's care? Y / N If yes, explain: _________________________

Are you taking any medicine at this time? Y / N Please specify: _________________________

Are you allergic to any medications? Y / N Please specify: _________________________

Are you allergic to the following medications?

Yes / No Penicillin **Yes / No** Tetracycline **Yes / No** Erythromycin **Yes / No** Aspirin **Yes / No** Dental Anesthetics **Yes / No** Codeine **Yes / No** Sulfa

Do you have any known allergies (latex, nickel, nuts, etc.)? Y / N Please specify:_________________________

Have you been hospitalized or had any surgeries? Y / N Please specify:_________________________

Do you smoke? Y / N How much per day? _______ Do you chew tobacco? Y / N Do you vape? Y / N How much per day?____

Are you currently or have you previously taken bisphosphonates? Y / N If yes, explain: _________________________

Have you had a sleep study? Y / N Have you been diagnosed with sleep apnea? Y / N Do you wear a CPAP? Y / N

Do you have any history of these?:

Yes / No Heart attack / Stroke	Yes / No Difficulty Breathing	Yes / No Heart Disorder/Murmur/Defects	Yes / No Hepatitis or Liver Disorder
Yes / No Anemia / Bleeding Disorders	Yes / No Emphysema	Yes / No Artificial valves	Yes / No Kidney or Bladder Disorder
Yes / No Prolonged Bleeding/Clotting Disorder	Yes / No Asthma	Yes / No Hypertension	Yes / No Ulcers / Colitis
Yes / No Bone Problem or Disorder	Yes / No Bronchitis	Yes / No Congenital Heart Disease	Yes / No Pacemaker
Yes / No Arthritis/Joint Swelling	Yes / No Tuberculosis	Yes / No Heart Surgery	Yes / No Emotional Disorders
Yes / No Artificial Joints	Yes / No Neurologic Disorder	Yes / No Rheumatic Fever	Yes / No Hearing difficulties
Yes / No AIDS or HIV	Yes / No Cerebral Palsy	Yes / No Pacemaker	Yes / No Drug/Alcohol Abuse
Yes / No Fever Blisters	Yes / No Convulsions/Seizures	Yes / No Mitral Valve Prolapse	Yes / No Daily Aspirin / Blood Thinner
Yes / No Cancer / Chemotherapy / Radiation	Yes / No Headaches	Yes / No Endocrine/Hormone Disorders	Yes / No Pregnant (For women)
Yes / No Sinus Problems	Yes / No Glaucoma	Yes / No Diabetes	__________ **Doctor's Initials**

If you are experiencing or have a history of any disease, condition, or problem not addressed, please explain:

____

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

Signature: _________________________ **Date**: _________________________