

# PATIENT INFORMATION

CONFIDENTIAL

PATIENT # \_\_\_\_\_

(PLEASE PRINT)

DATE \_\_\_\_\_

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
FIRST MI LAST

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

CHECK APPROPRIATE BOX:  MINOR  SINGLE  MARRIED  DIVORCED  WIDOWED  SEPARATED

PATIENT'S OR PARENT'S EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SPOUSE OR PARENT'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_

PERSON TO CONTACT IN CASE OF AN EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

# RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE?  YES  NO

# INSURANCE INFORMATION

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS OF EMPLOYER \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ GROUP # \_\_\_\_\_ UNION OR LOCAL # \_\_\_\_\_

INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOW MUCH IS YOUR DEDUCTIBLE? \_\_\_\_\_ HOW MUCH HAVE YOU USED? \_\_\_\_\_ MAX. ANNUAL BENEFIT? \_\_\_\_\_

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

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS OF EMPLOYER \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ GROUP # \_\_\_\_\_ UNION OR LOCAL # \_\_\_\_\_

INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOW MUCH IS YOUR DEDUCTIBLE? \_\_\_\_\_ HOW MUCH HAVE YOU USED? \_\_\_\_\_ MAX. ANNUAL BENEFIT? \_\_\_\_\_

**X**  
SIGNATURE OF PATIENT OR PARENT IF MINOR \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_  
 HOME ADDRESS \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
 \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
 BUSINESS ADDRESS \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_  
 \_\_\_\_\_ SOC. SEC. NO. \_\_\_\_\_

## PATIENT MEDICAL HISTORY

PHYSICIAN \_\_\_\_\_ OFFICE PHONE \_\_\_\_\_ DATE OF LAST EXAM \_\_\_\_\_

- |   |                          | YES                      | NO                       |   |
|---|--------------------------|--------------------------|--------------------------|---|
| 1. ARE YOU UNDER MEDICAL TREATMENT NOW?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS? IF YES, PLEASE SPECIFY.          |
| 2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| 3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? IF YES, WHAT MEDICATION(S) ARE YOU TAKING? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| 4. DO YOU USE TOBACCO?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8. WHEN WAS YOUR LAST COMPLETE PHYSICAL? _____  |
| 5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. WOMEN ONLY:  |
| 6. ARE YOU WEARING CONTACT LENSES?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | YES NO  |
|   |                          |                          |                          | A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? <input type="checkbox"/> <input type="checkbox"/> |
|   |                          |                          |                          | B) ARE YOU NURSING? <input type="checkbox"/> <input type="checkbox"/>                               |
|   |                          |                          |                          | C) ARE YOU TAKING BIRTH CONTROL PILLS? <input type="checkbox"/> <input type="checkbox"/>            |

10. PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> HIGH BLOOD PRESSURE    | <input type="checkbox"/> HEART DISEASE                | <input type="checkbox"/> CHEST PAINS           | <input type="checkbox"/> KIDNEY DISEASES              |
| <input type="checkbox"/> HEART ATTACK           | <input type="checkbox"/> CARDIAC PACEMAKER            | <input type="checkbox"/> EASILY WINDED         | <input type="checkbox"/> AIDS OR HIV INFECTION        |
| <input type="checkbox"/> RHEUMATIC FEVER        | <input type="checkbox"/> HEART MURMUR                 | <input type="checkbox"/> STROKE                | <input type="checkbox"/> THYROID PROBLEM              |
| <input type="checkbox"/> SWOLLEN ANKLES         | <input type="checkbox"/> ANGINA                       | <input type="checkbox"/> HAY FEVER / ALLERGIES | <input type="checkbox"/> HEPATITIS / JAUNDICE         |
| <input type="checkbox"/> FAINTING / SEIZURES    | <input type="checkbox"/> FREQUENTLY TIRED             | <input type="checkbox"/> TUBERCULOSIS          | <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE |
| <input type="checkbox"/> ASTHMA                 | <input type="checkbox"/> ANEMIA                       | <input type="checkbox"/> RADIATION THERAPY     | <input type="checkbox"/> STOMACH TROUBLES / ULCERS    |
| <input type="checkbox"/> LOW BLOOD PRESSURE     | <input type="checkbox"/> EMPHYSEMA                    | <input type="checkbox"/> GLAUCOMA              | <input type="checkbox"/> RESPIRATORY PROBLEMS         |
| <input type="checkbox"/> EPILEPSY / CONVULSIONS | <input type="checkbox"/> CANCER                       | <input type="checkbox"/> RECENT WEIGHT LOSS    | <input type="checkbox"/> OTHER _____                  |
| <input type="checkbox"/> LEUKEMIA               | <input type="checkbox"/> ARTHRITIS                    | <input type="checkbox"/> LIVER DISEASE         | _____   |
| <input type="checkbox"/> DIABETES               | <input type="checkbox"/> JOINT REPLACEMENT OR IMPLANT | <input type="checkbox"/> HEART TROUBLE         | _____   |

## COMMENTS

## PATIENT DENTAL HISTORY

PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

- |   |                          |   |                          |
|---|--------------------------|---|--------------------------|
| 1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?                       | <input type="checkbox"/> | 8. DO YOU HAVE FREQUENT HEADACHES?  | <input type="checkbox"/> |
| 2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?               | <input type="checkbox"/> | 9. DO YOU CLENCH OR GRIND YOUR TEETH?   | <input type="checkbox"/> |
| 3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?             | <input type="checkbox"/> | 10. DO YOU BITE YOUR LIPS OR CHEEKS, FREQUENTLY?                                | <input type="checkbox"/> |
| 4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?                               | <input type="checkbox"/> | 11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?                    | <input type="checkbox"/> |
| 5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?                | <input type="checkbox"/> | 12. HAVE YOU HAD ANY ORTHODONTIC WORK?  | <input type="checkbox"/> |
| 6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?                         | <input type="checkbox"/> | 13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?                 | <input type="checkbox"/> |
| 7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW? |                          | 14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? | <input type="checkbox"/> |
| A) CLICKING?  | <input type="checkbox"/> | 15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?                    | <input type="checkbox"/> |
| B) PAIN (JOINT, EAR, SIDE OF FACE)?                                     | <input type="checkbox"/> |   |                          |
| C) DIFFICULTY IN OPENING OR CLOSING?                                    | <input type="checkbox"/> |   |                          |
| D) DIFFICULTY IN CHEWING?   | <input type="checkbox"/> |   |                          |

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.

**X** \_\_\_\_\_ DATE \_\_\_\_\_  
 PATIENT, PARENT OR GUARDIAN