# PATIENT INFORMATION

Last _____ First _____ Middle In ____
Sex: M / F Birth date ___/___/___ Age ___ SS# _____
Marital Status _____ If a Minor? Guardian's Name _____
Reason for Visit _____
Whom May We Thank for Referring You? _____

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Phone: Home _____ Wk _____ Cell _____ Email address_____
Mailing address _____City_____ State____ Zip_____
ResidentialAddress_____City_____State____ Zip_____
Employer_____Occupation_____
Spouses Name_____ Birthdate ___/___/____ SS#_____

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**Emergency Contact Information**

Name _____ Relation _____
Phone # _____Address _____ City _____ State ___ Zip _____

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**Dental Insurance Information – (You don't need to fill out this section if you have a card we can copy☺)**

Insured's Name _____ SS# _____ Ins. Co Name _____
Group # _____ Local # _____ Phone # _____
Ins. Co Address _____ City _____ State ___ Zip _____
Secondary Dental insurance Information
**Insured's Name** _____ SS# _____ Ins. Co. Name _____
Group # _____ Local # _____ Phone # _____
Ins. Co. Address _____ City _____ State ___ Zip _____
**Self Pay**

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## Dental History

How long since your last dental Visit? _____
Exam?_____ X-rays? _____ Cleaning? _____
Previous Dentist _____ Phone _____
City _____State ____Zip _____
Are you interested in lightening your teeth? Y / N
From 1 to 10 how would you rate your smile? _____
If you change something about your smile what would it be?
_____

Do your gums bleed? Y / N Do you floss daily? Y / N
Have you had periodontal disease/ treatments? Y / N
Are your teeth sensitive? Hot / Cold / Sweets / Pressure
Are you aware of grinding or clenching? Y / N
Do you snore? Y / N
Do you have pain in the: head / ears / jaw / neck
Do you wear partial dentures or dentures? Y / N
If so, are you happy with them? Y / N
Have you worn Braces? Y / N
Are you being treated from Chronic Pain? Y / N
Your biggest concern about treatment?_____

## Health History

Are you under a physicians care? Y / N _____
Are you taking any medications? Y / N _____
_____

Any ALLERGIES to MEDICATIONS? Y / N
Please list _____
Are you Pregnant? Y / N Do you: smoke? Chew?

Circle any of the following that you have or have had:

AIDs/ HIV
Allergies
Alcoholism
Anemia
Arthritis
Angina Pectoris
Artificial Joints (when?) _____
Asthma
Back/Neck Problems
Blood Disease
Blood Transfusion
Bleeding Problems
Bruise Easily
Cancer (type)_____
Chemotherapy
Cold Sores
Cosmetic Surgeries
Diabetes
Dizziness
Drug Addictions
Epilepsy/Seizures
Fainting
Fever Blisters
Glaucoma
Hay Fever
Head Injuries
Heart Disease
Heart Murmur
Hepatitis A B C
Headache/Migraines
Heart Problems_____
High Blood Pressure
Jaundice
Kidney Disease
Latex Allergy
Liver Disease
Nervous Disorders
Pacemaker
Psychiatric Treatment
Radiation Treatment
Respiratory Problems
Rheumatic Fever
Rheumatism
Sinus Problems
Stomach Problems
Stroke
Thyroid Disease
Tuberculosis (TB)
Tumors
Ulcers
Venereal Diseases

**Patient (Guardian) Signature _____ Date _____**