

**Patient Information (Confidential)**

Name \_\_\_\_\_ Date \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth date \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-mail \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
If Student, Name of School \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Circle Appropriate: Minor Single Married Separated Divorced Widowed  
Spouse's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Closest Relative (name) \_\_\_\_\_ Phone \_\_\_\_\_  
Emergency Contact (not living with you) \_\_\_\_\_ Phone \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

**Responsible Party**

Responsible account holder \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Employer Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
Are you covered by dental Insurance? Primary \_\_\_\_\_ Secondary \_\_\_\_\_  
Insured's Name \_\_\_\_\_ SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth date \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Reason for today's visit? \_\_\_\_\_  
Do you have any general health problems? \_\_\_\_\_  
Are you currently under the care of a physician? \_\_\_\_\_

Do you have (or have you ever had) any of the following?

- Yes No 1. Allergic reaction to any medication, latex, or metal? \_\_\_\_\_  
Penicillin Aspirin Codeine Local Anesthetics Sulfa Other
- Yes No 2. Heart attack or heart disease or congestive heart failure/disease \_\_\_\_\_
- Yes No 3. Stroke \_\_\_\_\_
- Yes No 4. High blood pressure \_\_\_\_\_
- Yes No 5. Angina (chest pains) \_\_\_\_\_
- Yes No 6. Irregular heart beat, heart murmur, or mitral valve prolapse \_\_\_\_\_
- Yes No 7. Artificial heart valve \_\_\_\_\_
- Yes No 8. Rheumatic fever, rheumatic heart disease, bacterial endocarditis \_\_\_\_\_
- Yes No 9. Immunosuppressive condition (circle all that apply)  
Steroid Therapy (e.g. prednisone) Radiation or Cancer Therapy SLE (Lupus)  
Rheumatoid Arthritis HIV Organ Transplant Spleen removed other \_\_\_\_\_
- Yes No 10. Artificial joint(s) (mark dates placed) \_\_\_\_\_  
Hip \_\_\_\_\_ Knee \_\_\_\_\_ Ankle \_\_\_\_\_ Shoulder \_\_\_\_\_
- Yes No 11. Other artificial implants or devices \_\_\_\_\_
- Yes No 12. Bleeding problems, anemia, other blood disease \_\_\_\_\_
- Yes No 13. Diabetes \_\_\_\_\_
- Yes No 14. Thyroid disease \_\_\_\_\_
- Yes No 15. Long-term antibiotic use (greater than one month continuously) \_\_\_\_\_

- Yes No 16. Nervous system disease or seizures \_\_\_\_\_
- Yes No 17. Kidney disease \_\_\_\_\_
- Yes No 18. Hepatitis ( A, B, C, or D) or other liver disease \_\_\_\_\_
- Yes No 19. Muscle or joint disease or arthritis (osteo or rheumatoid) \_\_\_\_\_
- Yes No 20. Asthmas, tuberculosis, or other lung disease \_\_\_\_\_
- Yes No 21. Stomach or intestinal disease \_\_\_\_\_
- Yes No 22. Mental health condition – specify \_\_\_\_\_
- Yes No 23. Physical or mental disabilities that may require special care? \_\_\_\_\_
- Yes No 24. Impairment or hearing, sight or speech \_\_\_\_\_
- Yes No 25. Do you have or have you ever been treated for cancer? \_\_\_\_\_
- Yes No 26. Are you pregnant? \_\_\_\_\_ Are you nursing? \_\_\_\_\_
- Yes No 27. Do you have any disease, condition, or problem not listed here? \_\_\_\_\_
- Yes No 28. Have you ever been hospitalized or had surgery? \_\_\_\_\_
- Yes No 29. Do you have any undiagnosed symptoms? \_\_\_\_\_
- Yes No 30. Are you, or have you ever been addicted to a chemical substance? \_\_\_\_\_
- Yes No 31. Do you currently drink alcohol or use recreational drugs? \_\_\_\_\_
- Yes No 32. Do you smoke or use smokeless tobacco? \_\_\_\_\_
- Yes No 33. What type of tobacco product(s) do you use? \_\_\_\_\_
- Yes No 34. Do you regularly take herbal medicines or dietary supplements? \_\_\_\_\_

Specifically, do you take (circle all that apply):

Echinacea                  Garlic                  Ginger          Kava                  Valerian                  Turmeric

Fish Oil(>3g/day)          Feverfew                  Ginkgo          Vitamin E          St. John's Wort

- Yes No 35. Have you undergone current or past osteoporosis therapy?  
(Examples are: Fosamax, Actonel, Boniva pill form)
- Yes No 36. Have you undergone current or past therapy to reduce high blood calcium?  
(Bisphosphonate therapy) (Examples: intravenous Areadia, or Zometa)

#### DENTAL HISTORY

- Why did you leave your last dentist? \_\_\_\_\_
- What was the date of your last dental exam? \_\_\_\_\_
- Have you had any trouble associated with previous dental treatments? \_\_\_\_\_
- Do your gums bleed when you brush your teeth? \_\_\_\_\_
- Do you suffer from pain in the mouth, face, eyes, neck, throat, or headache? \_\_\_\_\_
- Are you happy with the appearance of your teeth? \_\_\_\_\_
- What would you change about your smile? \_\_\_\_\_
- Has fear ever prevented you from seeking dental treatment? \_\_\_\_\_
- Circle the types of dental treatment you have experienced: \_\_\_\_\_

Orthodontic          Dentures          Root Canal Treatment          Implants          Oral Surgery          TMJ

Periodontal Treatment          Extractions          Fillings          Other \_\_\_\_\_

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my children or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me, I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment services rendered on my behalf or my dependents.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_