

Patient Information

Date _____

Patient's Name _____
Last First Middle Male Female

_____ Street

_____ City State Zip Home Phone _____
 Birthdate _____ Cell Phone _____

Social Security # _____ Driver's License # _____

Employer _____ Occupation _____

Employer's Address _____ Phone # _____

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

Patient's Dentist _____ Email Address _____

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

Responsible Party Information (Legal Custody If Patient Is A Child)

Name _____
Last First Middle Marital Status

Address _____ How long at this address _____
Street City State Zip Home Phone _____
 Work Phone _____
 Cell Phone _____

Previous Address _____
Street City State Zip How Long At This Address _____
 Relationship to Patient _____

Social Security # _____ Birthdate _____

Employer _____ Occupation _____

Employer's Address _____ No. Years Employed _____

Driver's License # _____ State _____

Spouse's Name _____
Last First Middle

Spouse's Employer _____ Address _____
 Occupation _____ No. Years Employed _____ Work Phone _____

Spouse's Social Security # _____ Spouse's Birthday _____

Spouse's Driver's License # _____ State _____ Cell Phone _____

Insurance Information

PRIMARY INSURANCE Insured's Name _____
 Social Security # _____
 Insurance Company _____ Phone # _____

SECONDARY INSURANCE Insured's Name _____
 Social Security # _____
 Insurance Company _____ Phone # _____

Emergency Information

Name of nearest relative/friend not living with you _____ Relationship _____
 Complete Address _____
 _____ Phone _____

I understand that when appropriate, credit bureau reports may be obtained.

Signature (Parent's signature of minor) _____

SIBLINGS

Please provide name and birthdate of any siblings living in the same home.

Name _____ D.O.B. _____ Name _____ D.O.B. _____

Name _____ D.O.B. _____ Name _____ D.O.B. _____

MEDICAL HISTORY

Bone disease, heart trouble, TB, diabetes, kidney or liver involvements, epilepsy, rheumatic fever, hemophilia or any other major illness? _____

Any history of ear aches or repeated middle ear infections? _____

Have adenoids or tonsils been examined or removed? _____

Are there any allergies to medicines, foods, plants, etc.? If so, _____

Have you ever had asthma, hay fever, skin rashes, stuffy nose repeatedly? _____

Present medications? _____

Are you under care of a physician now? _____

Have any medical x-rays been taken in the past six months? _____

Have you ever had a metabolic or endocrine imbalance? _____

Have you ever had any nervous conditions? _____

Any other health problems not mentioned? _____

DENTAL HISTORY

Cavities? _____

Extractions? _____

Bleeding gums? _____

Teeth injured or broken? _____

Are lips often kept apart when at rest? _____

Is much breathing done through the mouth? _____

Have you ever noticed any speech problems? _____

Have there ever been any habits which might have caused the teeth to move such as thumb sucking, chewing on finger nails, lips, cheeks, tongue? _____

Do you have pain when chewing? _____

Do you play a musical instrument with a mouthpiece? _____

Does your mouth have any inherited characteristics? _____

Dental health of other family members? (regular visits) _____

Any friends or relatives treated here? _____

How long since you were cared for by a dentist? and had x-rays? _____