IMPORTANT CONFIDENTIAL INFORMATION

Today's Date_____

Full Name_____Age_____Birthdate_____

Nickname/Preferred name_____SS#_____

Responsible Party (If different from above)_____

Address_____

City_____State_____Zip_____

Home Phone #_____(Circle One) Married Single Divorced Widowed

Spouse's Name (If Applicable)_____

Email Address_____

Who Can We Thank For Referring You To Our Office?_____

Person To Contact In Case Of An Emergency_____

Phone Number of Person Above_____Relationship_____

Closest Relative Not Living with You_____Phone #_____

Client's Occupation_____

Client's Employer_____For How Long_____

Work Address_____

Work Phone #_____Ext._____

Spouse's Occupation (If Applicable)_____

Spouse's Employer_____For How Long_____

Spouse's Work Phone #_____Ext._____

IMPORTANT CONFIDENTIAL INFORMATION

Children	Age	Notes
_____	_____	_____
_____	_____	_____
_____	_____	_____

INSURANCE INFORMATION:
(Although we do not accept direct payment from insurance companies, we will enter your information and print a form with everything that the insurance company needs. We will ask you to sign this form and we will mail it in for you to help you get reimbursed.)

Insured Party:_____SS # of Insured:_____

Birthdate of Insured:_____

Relationship of Insured (circle one): Self Spouse Child

Employer:_____

Employer Address:_____

Employer Phone #:_____

Insurance Company:_____

Insurance Company Address:_____

Plan Name:_____Group #:_____

Patient ID #:_____

MEDICAL HISTORY

PATIENTS NAME:_____

TODAYS DATE: _____

1. Are you allergic to any medications or substance? . . . . . YES NO
If "yes," please list _____

2. Have you been a patient in a hospital in the past two years? . . . . . YES NO
If "yes," why? _____

3. Have you been under the care of a doctor (physician or other) in the past two years? . . . . . YES NO
If "yes," why? _____

4. Name(s) of Doctor(s) . . _____**Speciality** _____ **Phone** _____
_____**Specialty** _____ **Phone** _____
_____**Specialty** _____ **Phone** _____

5. Have you taken any prescription medications in the past two years? . . . . . YES NO
If "yes," what? _____

6. Are you currently taking any prescription medications? . . . . . YES NO
If "yes," what and why? _____

7. Have you ever had any of the following?

Heart Disease	Bruise Easily	Diabetes/Blood Sugar Problems
Chest Pain	Stroke	Arthritis/Rheumatism
High Blood Pressure	Epilepsy/Seizures	Glaucoma
Heart Murmur	Fainting/Dizzy Spells	Fever Blisters/Cold Sores
Rheumatic Fever	Radiation Treatment	Hepatitis
Other Heart Problems	Chemotherapy	Other Liver Problems
Heart Surgery	Cancer	Drug/Alcohol Addiction
Artificial Joint(s)	Kidney Problems	Psychiatric Treatment
Anemia	Ulcer/Stomach Disorders	Headaches
Sickle Cell Disease	Emphysema	Skin Conditions/Problems
Sickle Cell Trait	Persistent Cough	Anorexia/Bulimia
H.I.V./AIDS	Tuberculosis (TB)	Other/Notes_____
Leukemia	Asthma	_____
Hemophilia	Sinus Trouble	_____
Blood Transfusion	Allergies/Hives	_____
Other Blood Problems	Thyroid Problems	

8. Frequent or severe headaches or head pain? _____YES_____ NO

9. Phobias, Unusual Fears, Severe Anxieties, Depression, Psychoses, Etc . . . . . YES NO
If "yes," what? _____
_____
_____

10. Do you have any complaints or conditions involving your eyes, ears or nose? . . . . . YES NO

11. Do you SNORE? . . . . . YES NO

12. How many cigarettes/cigars/pipes do you smoke per day? _____

13. How many drinks of alcoholic beverage do you have per day? _____
per week? _____

<u>WOMEN ONLY</u>

Are you taking Birth Control Pills/Shot? . . . . . YES NO

Are you pregnant? . . . . . YES NO

DENTAL HISTORY

1. What are your dental concerns? _____

   _____

   _____

2. When was your last visit to a dental office? _____
3. When was the last time you had dental x-rays taken?_____
4. Are you happy with the appearance of your teeth and smile? . . . . . YES NO

   If "No," why?_____

   _____

   If "yes," why? _____
5. Have you always had your teeth professionally cleaned at least once a year? . . . . . YES NO
6. Do you brush twice per day? . . . . . YES NO
7. Do you use dental floss at least once per day? . . . . . YES NO
8. Do your gums bleed when you brush and/or floss? . . . . . YES NO
9. Do your gums bleed when you eat? . . . . . YES NO
10. When you brush your teeth, do you brush your tongue also? . . . . . YES NO
11. Does food or dental floss catch between your teeth? . . . . . YES NO
12. Are your teeth sensitive to hot, cold or pressure? . . . . . YES NO
13. Do you have (or have had) pain or clicking in your jaw joints? . . . . . YES NO
14. Have you had any injury(ies) to your teeth, jaws or face? . . . . . YES NO

    If "yes," please explain _____

    _____
15. Are you worried or nervous about dental treatment? . . . . . YES NO

    If "yes," please explain _____

    _____
16. Have you ever fainted during a dental visit? . . . . . YES NO
17. Have you ever experienced unusual reaction(s) to dental anesthetics or medications? YES NO

    If "yes," please explain _____

    _____
18. Have you ever experienced prolonged bleeding after a dental visit? . . . . . YES NO
19. Have you had any other complications or bad experiences in the dental office? . . . YES NO

    If "yes," please explain _____

    _____
20. What kind of dental care did your parents have? _____

    _____

    _____
21. Do (did) your parents have their natural teeth? . . . . . YES NO