Patient Information Form

Date					
Name				Soc. Sec #	
Address					
City				State	Zip
Home Phone		Work		Cell	
Email Address					
☐ Male	☐ Female	Birthday	Age	☐ Single	☐ Married
Patient employed by			Occupation		
Whom can we thank for referring you?					
Notify in case of Emergency			Relationship to you		
Home Phone		Work		Cell	

Primary Insurance

Person responsible for the account		Are they a patient here? ☐ yes ☐ no
Relationship to Patient	Birthdate	Soc. Sec#
Address (if different from Patient)		
City	State	Zip
Home Phone	Work	Cell
Person responsible employed by	Occupation	
Insurance Company	Phone:	
Subscriber #	Group #	Contract#
Name of other dependents under this plan		

Dental History

Former Dentist	Phone
Date of last visit	Date of last X-Rays

Check if you have had problems with any of the following

☐ Bad Breath	☐ Food Collection between teeth	☐ Periodontal treatment
☐ Bleeding Gums	☐ Grinding or clenching teeth	☐ Clicking or popping jaw
☐ Sensitivity to Cold	☐ Loose teeth or broken fillings	☐ Sores or Growths in mouth
☐ Sensitivity to Hot	☐ Sensitivity when biting	☐ Sensitivity to sweets

How often do you Brush?	How often do you Floss?
How do you feel about the appearance of your teeth?	
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?	
Other information about your dental health or previous treatment?	
Reason for your visit today?	

Medical History

Physician's Name	Phone
Date of last Visit	Any serious illnesses or operations?
Are you currently under a physician's care?	
Have you ever had a blood transfusion?	Date(s)

Women: Are you pregnant?	Nursing?	Taking Birth control Pills?

Check if you have had any of the following?

- ☐ AIDS/HIV Positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Anxiety
- ☐ Artificial heart valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Atopic (allergy prone)
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cortisone treatments
- ☐ Cough, persistent
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food Allergies
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart Problems: describe _____
- ☐ Hemophilia/ abnormal bleeding
- ☐ Oral Herpes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Jaw Pain
- ☐ Kidney disease or malfunction
- ☐ Liver disease
- ☐ Material Allergies (latex, wool, metal, etc)
- ☐ Mitral valve prolapse
- ☐ Osteoporosis
- ☐ Pacemaker / Heart surgery
- ☐ Psychiatric care
- ☐ Rapid weight loss or gain
- ☐ Radiation treatment
- ☐ Respiratory treatment
- ☐ Rheumatic / Scarlet Fever
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Surgical implant
- ☐ Swelling of feet or ankles
- ☐ Thyroid disease or malfunction
- ☐ Tobacco habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer/Colitis

List any medications you are currently taking:
List any drug allergies:

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.