ADULT PATIENT INFORMATION

Name: ______________________________ Date: ______________________

What do you prefer to be called? __________ Phone #: ___________ Cell #: _________

Address: ______________________________ City/State/Zip: ________________

Date of Birth: ______________________ Social Security Number: ________________

E-Mail Address: ____________________ Employer: ________________________

Business Number: ______________ Employer Address: ________________________

Spouse's Name (or Parent's Name): __________________ Spouse's Cell #: ___________

Spouse's Social Security Number: ____________ Spouse's Employer: ________________

Spouse's Business Number: _____________ Spouse's Employer Address: _____________

Person Responsible for Payment of Account: __________________________________

Address (if different than home address): ___________________________________

Referred to our office by: ____

Primary Dental Insurance Information	Secondary Dental Insurance Information
Insured's Name: ____________________	Insured's Name: ____________________
Insured's Birthdate: _________________	Insured's Birthdate: _________________
Employer Name: ____________________	Employer Name: ____________________
Insurance Company: _________________	Insurance Company: _________________
Insurance Address & Phone #: __________ ______________________________	Insurance Address & Phone #: __________ ______________________________
Policy #: _________ Insured's ID#: ______	Policy #: _________ Insured's ID#: ______

In case of emergency call: _________________ Relationship: ______________________

Phone Number: __________ Cell Number: ___________ Address: __________________

Previous Dentist: ____________________ How long since last dental visit? ____________

-Please Note-

Payment is expected at time of service. If you provide your insurance form and proper information, we will file your insurance as a courtesy. However, you are responsible for your account within the limits of our credit policy, regardless of insurance coverage.

SIGNATURE: ______________________________

MEDICAL HISTORY

PATIENT NAME ____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

	Yes	No	N/A	
Are you under a physician's care now?	☐	☐	☐	If yes, please explain: ______________
Have you ever been hospitalized or had a major operation?	☐	☐	☐	If yes, please explain: ______________
Have you ever had a serious head or neck injury?	☐	☐	☐	If yes, please explain: ______________
Are you taking any medications, pills, or drugs?	☐	☐	☐	If yes, please explain: ______________
Do you take, or have you taken, Phen-Fen or Redux?	☐	☐	☐	
Are you on a special diet?	☐	☐	☐	

	Yes	No	N/A
Do you use tobacco?	☐	☐	☐
Do you use controlled substances?	☐	☐	☐

Women: Are you (check if yes) ☐ Pregnant / Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: ______________

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes ☐ No ☐ N/A

Comments:

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*Condition may require medication N/A - Not answered by patient

DENTAL HISTORY

1. What is your primary dental concern? ______________
2. How long since your last dental visit? ______________
3. Your previous dentist's name: ______________
4. Have you ever had any unusual problems or complications with previous dental treatment? ☐ Yes ☐ No
   If so, explain ______________
5. Have you ever had any gum treatment or surgery?............ ☐ Yes ☐ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE: ______________________ DATE ______________