

Patient Information Form

Today's Date _____

Patient Name: First _____ MI _____ Last _____ Nickname _____

Address: Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

E-mail address _____

By Providing your e-mail address you agree to receive (check one or both) ☐ Appointment Reminders ☐ Practice NewsletterWhat is your preferred method of contact? ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ E-Mail

Social Security Number _____ Date of Birth _____

Drivers License # _____ State _____

Patient Employed By _____ Occupation _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Sex ☐ Male ☐ Female Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

In case of emergency, who should be notified? _____

Relationship to Patient _____ Home Phone _____ Mobile Phone _____

Is the patient a Minor? ☐ Yes ☐ No Full-time Student ☐ Yes ☐ No Name of School _____

Name of Responsible Party: First _____ Last _____

Date of Birth _____ Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other _____If patient is a Minor, primary residency ☐ Both Parents ☐ Mom ☐ Dad ☐ Step Parent ☐ Shared Custody ☐ Guardian

Address: (if different from patient) Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

Employer (if different from above) _____ Occupation _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Dental Benefit Plan Information

Primary Dental Plan Name _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ Date of Birth _____ ID Number _____

Policy Number _____ Patient Relationship to Insured _____

Secondary Dental Plan Name _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ Date of Birth _____ ID Number _____

Policy Number _____ Patient Relationship to Insured _____

Patient's Name: _____

DENTAL HISTORY

Please check any of the following problems that apply to you.

	Yes	No
-Sensitivity (hot; cold, sweet, pressure)	<input type="checkbox"/>	<input type="checkbox"/>
Where? UR LR UL LL		
-Headaches, earaches, neck pain	<input type="checkbox"/>	<input type="checkbox"/>
-Jaw joint pain	<input type="checkbox"/>	<input type="checkbox"/>
-Teeth or fillings breaking	<input type="checkbox"/>	<input type="checkbox"/>
-Grinding or clenching teeth	<input type="checkbox"/>	<input type="checkbox"/>
-Bleeding, swollen or irritated gums	<input type="checkbox"/>	<input type="checkbox"/>
-Loose, tipped or shifting teeth	<input type="checkbox"/>	<input type="checkbox"/>
-Bad breath	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you had any of the following?		
-Dentures	<input type="checkbox"/>	<input type="checkbox"/>
-Partial dentures	<input type="checkbox"/>	<input type="checkbox"/>
-Braces	<input type="checkbox"/>	<input type="checkbox"/>
-Periodontal (gum) treatments	<input type="checkbox"/>	<input type="checkbox"/>

Please share the following dates:

- Your last cleaning _____ / _____
- Your last oral cancer screening _____ / _____
- Your last complete X-Rays _____ / _____

Name of Previous Dentist _____

City _____ State _____

Phone Number _____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____

If you could whiten your teeth for a cost anyone could afford, would you do it?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Do you smoke or use chewing tobacco?

<input type="checkbox"/>	<input type="checkbox"/>
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How much? _____ For how long? _____

If I could change my smile, I would:

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

ON A SCALE OF 1-10, WITH 10 BEING THE HIGHEST RATING:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist? _____

MEDICAL HISTORY

Please check any of the following problems/conditions that apply to you:

	YES	NO		YES	NO		YES	NO
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>
Allergies (Seasonal)	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	HPV (Human Papilloma Virus)	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Angina (Chest pain)	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Lesions (Congenital)	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness/Depression	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant Currently	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Radiation (head/neck)	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Medication	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
						Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
						Seizures	<input type="checkbox"/>	<input type="checkbox"/>
						Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
						Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
						Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
						Stroke	<input type="checkbox"/>	<input type="checkbox"/>
						Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
						Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
						Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
						Venereal Diseases	<input type="checkbox"/>	<input type="checkbox"/>
						Other	_____	

Are you allergic or have you reacted adversely to any of the following medications?

	YES	NO		YES	NO		YES	NO
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Percodan	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline	<input type="checkbox"/>	<input type="checkbox"/>
Darvon	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Nitrous Oxide	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetic	<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>
						Valium	<input type="checkbox"/>	<input type="checkbox"/>
						Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
						Sulfa	<input type="checkbox"/>	<input type="checkbox"/>
						Other	_____	

Have you ever taken any of the following medications?

	YES	NO		YES	NO
Actonel	<input type="checkbox"/>	<input type="checkbox"/>	Zometa	<input type="checkbox"/>	<input type="checkbox"/>
Aredia	<input type="checkbox"/>	<input type="checkbox"/>	Boniva	<input type="checkbox"/>	<input type="checkbox"/>
Fosamax	<input type="checkbox"/>	<input type="checkbox"/>	Herbal	<input type="checkbox"/>	<input type="checkbox"/>
Reclast	<input type="checkbox"/>	<input type="checkbox"/>	Supplements		

Are you under a physician's care? What for?

What medications are you currently taking?

Family Physician _____

Phone Number _____

Consent:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

Patient Signature (Parent if child) _____

Date _____

Dentist Signature _____