PATIENT INFORMATION

How did you hear about our office? ______________________________

Name: (First) ____________ (Last) ____________ Birthdate: M ____ D ____ Y ________

Address: ____________________ City: ____________ Prov: ______ PC: ________

Cell Phone: ____________________ Work Phone: ____________________

Home Phone: ____________________ Email: ____________________

Drivers License # : ____________________

Emergency Contact: ____________________ Phone # : ____________________

Family Doctor: ____________________ Phone # : ____________________

INSURANCE INFORMATION

Primary Insurance:

Policy Holder: ______________________________ Birthdate: M ____ D ____ Y ________

Insurance Company: ____________ Employer: ____________ Policy # : ____________

Cert/ID # : ____________ Basic (A) % : ________ Major (B) % : ________ Yearly Max: ____________

Secondary Insurance:

Policy Holder: ______________________________ Birthdate: M ____ D ____ Y ________

Insurance Company: ____________ Employer: ____________ Policy # : ____________

Cert/ID # : ____________ Basic (A) % : ________ Major (B) % : ________ Yearly Max: ____________

I, the undersigned, understand that the information contained in themedical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care providers as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine the necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependants. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

Signature: ____________________ **Print Name:** ____________________

Please Circle One: Self Parent Guardian **Date:** ____________________

MEDICAL HISTORY: (This information is necessary for your dental care and will remain confidential.)

Please circle Yes or No in response to the following questions:

Are you currently under the care of a physician due to a specific medical condition? **Yes** **No**

Are you taking any prescription or non-prescription medications? **Yes** **No**

If you answered **Yes**, please list the medication and reason for the medication.

Medication: ______________________ **Reason:** ______________________

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Medication: ______________________ **Reason:** ______________________

Are you allergic to or have had an adverse reaction to any medications? **Yes** **No**

If you answered **Yes**, please circle the medication that you are allergic to or had a reaction to:

Aspirin Barbiturates Codeine Erythromycin Local Anesthetic Penicillin Sulfa Valium

Other: ______________________

Have you ever been warned against taking any other medications? Which? ____________ **Yes** **No**

Do you suffer from any allergies (hay fever, latex, etc.)? Which? ____________ **Yes** **No**

Do you bruise easily or have prolonged bleeding? **Yes** **No**

Do you smoke or use tobacco products? If Yes, how much per day? ____________ **Yes** **No**

Women: Are you pregnant? If Yes, what is your due date? ____________ **Yes** **No**

Do you have or have you ever had any of the following? Please check appropriate circles or ○ None

○ Artificial Joints	○ Heart Disease	○ Kidney Disease	○ Radiation/Chemotherapy TX
○ Artificial Heart Valve	○ Heart Surgery	○ Low Blood Pressure	○ Rheumatic Fever
○ Blood Disorder	○ Heart Murmur	○ Liver Disease	○ Mental/Nervous Disorder
○ Cancer	○ Hepatitis A B C	○ Lung Disease	○ Stroke
○ Diabetes	○ High Blood Pressure	○ STD	○ Thyroid Disease
○ Emphysema	○ HIV Positive (AIDS)	○ Migraines	

Do you have any disease, condition, or problem not listed? ______________________

Dental History:

What is the reason for today’s visit? ______________________

How frequently do you see a dentist? ○ 3 - 6 Months ○ Annually ○ Other

When was your last dental visit? ____________ When were your last dental x-rays? ____________

How often do you brush your teeth? ____________ How often do you floss your teeth? ____________

Are your teeth sensitive to: ○ Cold ○ Sweets ○ Heat ○ Other

Do your gums bleed when: ○ Brushing ○ Flossing ○ Never

Do you grind or clench your teeth? ______________________

Are you satisfied with the way your teeth feel? ______________________

Have you ever had any problems with previous dental treatments? Please explain ____________

What, if anything, would you change about your smile? ______________________