PATIENT INFORMATION *(Please Print)*

Date _____

Name ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. _____

☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed Age _____ Date of birth _____

Home address _____ City _____ Zip _____

Home phone _____ Business phone _____ ext. _____ Social Security # _____

Email address: _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's occupation _____

Spouse's Soc. Sec. # _____ Person responsible for bill _____

Dental Insurance ☐ Yes ☐ No If Yes, group carrier _____ Group # _____

Whom may we thank for referring you to our office? _____

Call in case of emergency _____ Relationship _____ Phone _____

Reason for visit _____

MEDICAL HEALTH

Name and address of Physician _____

Physician's phone # _____ Last complete physical? _____

Overall general health ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you want whiter teeth? ☐ Yes ☐ No Do you occasionally suffer from cold sores? ☐ Yes ☐ No

Do you or anyone you know have a snoring problem? ☐ Yes ☐ No Do you suffer from headaches? ☐ Yes ☐ No

Please check Yes or No to all conditions:

Yes	No		Yes	No	
☐	☐	Heart murmur or congenital heart defect	☐	☐	Chemical dependency
☐	☐	Heart surgery or heart disease	☐	☐	Headaches
☐	☐	Rheumatic fever	☐	☐	Recent weight loss
☐	☐	Heart pacemaker	☐	☐	Convulsions or epilepsy
☐	☐	Abnormal blood pressure HIGH / LOW	☐	☐	Dizziness or fainting spells
☐	☐	Bleeding problems	☐	☐	Stroke
☐	☐	Diabetes	☐	☐	Lung problems or tuberculosis
☐	☐	Kidney disease	☐	☐	Thyroid disease
☐	☐	Jaundice or liver disease	☐	☐	Glaucoma
☐	☐	Cancer	☐	☐	Ulcers
☐	☐	Hepatitis	☐	☐	Arthritis
☐	☐	Venereal disease	☐	☐	Joint replacement
☐	☐	HIV +	☐	☐	Blood disease, ie. anemia
☐	☐	Herpes	☐	☐	Sinus trouble
☐	☐	Hemophilia	☐	☐	Females only: Are you pregnant?
☐	☐	Radiation treatment	☐	☐	Are you currently under the care of a physician?
			☐	☐	Are you taking any medications?

If Yes, please list and give reason for taking: _____

Are you allergic or sensitive to:

☐	☐	Penicillin
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Demerol
☐	☐	Local anesthetics like Novocaine
☐	☐	Other drugs, medicines or foods (list) _____

Other medical problems not listed above: _____

DENTAL HEALTH

On scale from 1-10 (10 being highest) what priority do you give your teeth? _____

Name and address of former dentist _____

When was your last visit? _____ What was done at that time? _____

Yes	No		Yes	No	
☐	☐	Are your teeth sensitive to sweets? Temperature?	☐	☐	Do your gums bleed or have pain?
☐	☐	Do you notice popping in your jaw?	☐	☐	Do you clench or grind your teeth?
☐	☐	Have you had any teeth removed?	☐	☐	Have you had orthodontic treatment?

PERMIT FOR TREATMENT

This is to certify that I, undersigned, consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated and I will assume responsibility for fees associated with those procedures.

Patient's (Parent's) Signature _____ Date _____