CHIEF COMPLAINT: _____ **DATE:** _____

PATIENT INFORMATION

NAME _____ MALE _____ FEMALE _____
FIRST LAST MI

SINGLE ____ MARRIED ____ MINOR ____ BIRTH DATE _____ AGE _____

HOME ADDRESS _____
NUMBER & STREET CITY STATE ZIP

PHONE NUMBERS _____ SS# _____
HOME WORK

EMAIL ADDRESS _____ REFERRED BY _____

FINANCIAL INFORMATION

METHOD OF PAYMENT ____CASH ____CHECK ____VISA ____MC ____INSURANCE ____MEDICAID ____OTHER

DENTAL INSURANCE CO _____ GROUP # _____

OTHER DENTAL INSURANCE _____ NOTICE: Insurance is filed as a courtesy.
Patient is responsible for all costs incurred.

EMPLOYER _____ POSITION _____ HOW LONG _____

PERSON RESPONSIBLE FOR PAYMENT IF DIFFRENT FROM ABOVE:

NAME _____
FIRST LAST MI

ADDRESS _____
NUMBER & STREET CITY STATE ZIP

SOCIAL SECURITY # _____ DL# _____ LICENSING STATE _____

MEDICAL INFORMATION

YES/NO

___ ___ allergic to medications; which ones?
___ ___ do you need premedication before appointment
___ ___ AIDS/HIV
___ ___ are you pregnant
___ ___ birth control/medication
___ ___ artificial joint/artificial heart valve
___ ___ any kind of heart trouble (heart murmur, MVP)
___ ___ stroke
___ ___ high/low blood pressure
___ ___ rheumatic fever
___ ___ asthma
___ ___ emphysema
___ ___ cancer
___ ___ liver trouble
___ ___ hepatitis (A,B,C,D)
___ ___ tuberculosis
___ ___ diabetic (controlled/uncontrolled)
___ ___ recent infections
___ ___ venereal disease

HAVE YOU EVER HAD

YES/NO

___ ___ smoke/drink alcohol
___ ___ drug/alcohol addiction
___ ___ frequent/severe headaches
___ ___ dizziness/fainting
___ ___ periodic seizures
___ ___ epilepsy/date of last seizure _____
___ ___ sinusitis/hay fever
___ ___ cortizone or ACTH treatment
___ ___ thyroid condition
___ ___ kidney trouble
___ ___ anemia
___ ___ psychiatric treatment
___ ___ arthritis
___ ___ nervous disorder
___ ___ are you under the care of a physician
___ ___ are there any other conditions the doctor should be aware of?
___ ___ are you taking any medications?

DENTAL INFORMATION

___ ___ have you ever had problems with local anesthetic?
___ ___ clenching/grinding
___ ___ have you ever been diagnosed with periodontal disease
___ ___ do your gums bleed during brushing
___ ___ unpleasant taste or bad breath
___ ___ tooth sensitivity
___ ___ concerned about snoring
___ ___ unfavorable dental experience
___ ___ are you concerned with color of teeth
___ ___ would you like information on proper nutrition
___ ___ other?

I HEREBY CERTIFY THAT ALL OF THE INFORMATION ON THIS FORM IS CORRECT.

SIGNATURE OF PATIENT/PARENT IF MINOR: _____ Dr. s Initial _____