

Patient Information

Date ____/____/20____

- Female Single
 Male Widowed
 Married Divorced

Patient's Name _____
Last, First Middle Nickname

Address _____
Street City State ZIP

Home Phone (____) _____ Work Phone (____) _____

If a child, give Parent's or Guardian's Name _____
Last First Middle

Spouse's Name _____
Last, First Middle Nickname

Home Phone (____) _____ Work Phone (____) _____

Driver's Lic. # _____

Patient's Birthdate _____

Soc. Sec. # _____

Birthdate _____

Soc. Sec. # _____

EMPLOYMENT INFORMATION

Patient's Employer _____

Present Position _____

Address _____
Street City State ZIP

No. of Yrs. _____

Spouse's Employer _____

Present Position _____

Address _____
Street City State ZIP

No. of Yrs. _____

DENTAL INSURANCE INFORMATION (Primary)

Insured's Name _____ Insured's Soc. Sec. No. _____
Last First Middle

Dental Insurance Company _____ Group No. _____ Local No. _____

Insurance Company Address _____

Date of Employment _____ Effective Date of Dental Insurance _____

DENTAL INSURANCE INFORMATION (Secondary)

Insured's Name _____ Insured's Soc. Sec. No. _____
Last First Middle

Dental Insurance Company _____ Group No. _____ Local No. _____

Insurance Company Address _____

Date of Employment _____ Effective Date of Dental Insurance _____

EMERGENCY NOTIFICATION INFORMATION

In case of emergency, who should be notified?

Name _____ Address _____ Phone _____

Name _____ Address _____ Phone _____

Whom may we thank for referring you? _____

Medical Questionnaire

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate to your particular needs.

Why are you seeking dental treatment? _____

Is this for emergency care? YES NO

Do you feel nervous about having dental treatment? YES NO

When was your last dental visit? _____ For what? _____

Are you in good health now? YES NO

Are you under the care of another doctor? YES NO

If so, what is the condition? _____

Have you ever been hospitalized? YES NO

If yes, explain: _____

Have you ever had excessive bleeding following an extraction, laceration or injury? YES NO

(WOMEN) Are you pregnant? _____ Due Date? _____

Do you use tobacco in any form? YES NO

Do you use alcoholic beverages? YES NO

Do you use recreational drugs? YES NO

Do you require antibiotic premedication before dental visits? YES NO

Do you have or have you ever had any of the following:

Anemia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	High or Low blood pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Heart disease/Heart attack	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Thyroid disorder	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Heart murmur/Mitral Valve Prolapse	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Rheumatic fever	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Stroke	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hepatitis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Heart valve replacement	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Jaundice	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Pacemaker	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Epilepsy/Seizures	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Heart surgery	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Joint replacement	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Glaucoma	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Arthritis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Angina Pectoris	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Allergies/Hives	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cancer/Tumors	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Allergies to: Latex	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Radiation/Chemotherapy	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Penicillin	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Headaches	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Novocaine	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Dizziness/Fainting	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Codeine	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Abnormal bleeding	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Aspirin	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Emphysema	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Other	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Sinus problems/Hay fever	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Tuberculosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Kidney disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Ringing ears/Hearing loss	<input type="checkbox"/> YES	<input type="checkbox"/> NO
AIDS or HIV-positive	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Ulcers	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Pain in jaw joints/TMJ	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Joint replacement/Pins	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Periodontal Disease/Treatment	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Psychiatric treatment	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Excessive bruising	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Dental implants	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Are you taking any medications? Please list: _____

Is there any disease, condition, or problem not listed above? Please list: _____

Have you ever had any trouble with previous dental work? _____

To the best of my knowledge, all the preceding answers are true and correct.
I will inform your office of any changes at next appointment.

Signature _____ Date _____