

CIRCLE ONE MRS., MISS, MS., MR., DR.

PATIENT NAME: _____ BIRTH DATE: _____

SOCIAL SECURITY #: _____ SEX: _____ GENERAL DENTIST: _____

PERSON RESPONSIBLE FOR ACCOUNT: _____ PHONE: _____

PATIENT ADDRESS: _____ APT# _____ CITY: _____

ZIP CODE: _____ PHONE: _____ PAGER/CELL: _____

PATIENT EMPLOYER: _____ PHONE: _____

EMPLOYER ADDRESS: _____ CITY: _____

SPOUSE EMPLOYER: _____ PHONE: _____

EMPLOYER ADDRESS: _____ CITY: _____

PARENT EMPLOYER(IF MINOR): _____ PHONE: _____

EMPLOYER ADDRESS: _____ CITY: _____

DENTAL INSURANCE INFORMATION

PRIMARY INS. CO. NAME: _____ INSURED NAME: _____

SOCIAL SECURITY #: _____ ACCOUNT #: _____ BIRTH DATE: _____

SECONDARY INS. CO. NAME: _____ INSURED NAME: _____

SOCIAL SECURITY #: _____ ACCOUNT #: _____ BIRTH DATE: _____

MEDICAL INSURANCE INFORMATION

PRIMARY INS. CO. NAME: _____ INSURED NAME: _____

SOCIAL SECURITY #: _____ ACCOUNT #: _____ BIRTH DATE: _____

SECONDARY INS. CO. NAME: _____ INSURED NAME: _____

SOCIAL SECURITY #: _____ ACCOUNT #: _____ BIRTH DATE: _____

ACCIDENTAL INFORMATION (IF APPLICABLE)

DATE OF ACCIDENT: _____ WORKMANS COMP: YES / NO

WHERE& WHAT HAPPENED: _____

WHERE DO WE FILE CLAIMS: _____

WHO CAN WE CONFIRM WITH (AGENT NAME): _____ PHONE #: _____

CLAIM NUMBER: _____

List any medications which have caused an allergic reaction:

- | | | |
|---|--|------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N Antibiotics | <input type="checkbox"/> Y <input type="checkbox"/> N Metals | Other allergens: _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Barbiturates | <input type="checkbox"/> Y <input type="checkbox"/> N Plastic | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N Sedatives | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Iodine | <input type="checkbox"/> Y <input type="checkbox"/> N Sleeping pills | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Latex | <input type="checkbox"/> Y <input type="checkbox"/> N Sulfa drugs | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Local anesthetics | | |

List any medications you are currently taking:

- | | | |
|--|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Antacids | <input type="checkbox"/> Y <input type="checkbox"/> N Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N Pain medication |
| <input type="checkbox"/> Y <input type="checkbox"/> N Antibiotics | <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone | <input type="checkbox"/> Y <input type="checkbox"/> N Sleeping pills |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anticoagulants | <input type="checkbox"/> Y <input type="checkbox"/> N Diet pills | <input type="checkbox"/> Y <input type="checkbox"/> N Sulfa drugs |
| <input type="checkbox"/> Y <input type="checkbox"/> N Antidepressants | <input type="checkbox"/> Y <input type="checkbox"/> N Heart medication | <input type="checkbox"/> Y <input type="checkbox"/> N Tranquilizers |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anti-inflammatory drugs
(non-steroid) | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure medication | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Barbiturates | <input type="checkbox"/> Y <input type="checkbox"/> N Insulin | Other current medications: _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood thinners | <input type="checkbox"/> Y <input type="checkbox"/> N Muscle relaxants | _____ |
| | <input type="checkbox"/> Y <input type="checkbox"/> N Nerve pills | _____ |

Medical History

- | | | |
|---|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Heart pacemaker | <input type="checkbox"/> Y <input type="checkbox"/> N Osteoarthritis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arteriosclerosis | <input type="checkbox"/> Y <input type="checkbox"/> N Heart valve replacement | <input type="checkbox"/> Y <input type="checkbox"/> N Osteoporosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Heartburn or a sour taste
in the mouth at night | <input type="checkbox"/> Y <input type="checkbox"/> N Poor circulation |
| <input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune disorders | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Prior orthodontic treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding easily | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Recent excessive weight
gain |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chronic sinus problems | <input type="checkbox"/> Y <input type="checkbox"/> N Immune system disorder | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chronic fatigue | <input type="checkbox"/> Y <input type="checkbox"/> N Injury to
<input type="checkbox"/> Face <input type="checkbox"/> Neck
<input type="checkbox"/> Head <input type="checkbox"/> Mouth <input type="checkbox"/> Teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congestive heart failure | <input type="checkbox"/> Y <input type="checkbox"/> N Insomnia | <input type="checkbox"/> Y <input type="checkbox"/> N Swollen, stiff or painful
joints |
| <input type="checkbox"/> Y <input type="checkbox"/> N Current pregnancy | <input type="checkbox"/> Y <input type="checkbox"/> N Irregular heart beat | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw joint surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillectomy (have had) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty concentrating | <input type="checkbox"/> Y <input type="checkbox"/> N Low blood pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Wisdom teeth extraction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dizziness | <input type="checkbox"/> Y <input type="checkbox"/> N Memory loss | Other medical history:
_____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N Migraines | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Morning dry mouth | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fibromyalgia | <input type="checkbox"/> Y <input type="checkbox"/> N Muscle spasms or
cramps | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent sore throats | <input type="checkbox"/> Y <input type="checkbox"/> N Needing extra pillows to
help breathing at night | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Gastroesophageal Reflux
Disease (GERD) | <input type="checkbox"/> Y <input type="checkbox"/> N Nighttime sweating | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hay fever | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart disorder | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart pounding or beating
irregularly during the night | | |

Patient Signature _____

Date _____

