



Patient Information

FName: _____ MI: _____ LName: _____ Male / Female

Mailing Address: _____ Birthdate: _____

City/State/Zip: _____ Soc Sec #: _____

Home Phone: _____ Cell: _____ Marital Status: _____

Email: _____ Are texts and emails okay? Yes or No

Responsible Person (if under age 18):

FName: _____ MI: _____ LName: _____ Male / Female

Relationship to Patient: _____ Address: _____
(if different)

DOB: _____ SSN: _____

Phone Number: _____

Insurance Information:

Do you have insurance: Yes or No

Insurance Company: _____ Subscriber's Name: _____

Subscriber's DOB: _____ SSN: _____ Employer: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Contact's Phone Number: _____ Alternate Number: _____

Name of your previous Dentist: _____ Last Visit: _____

Are you having any problems with your teeth now?: Yes or No

Problems: _____

How did you hear about our office?: _____

Would you be interested in financing? Yes or No

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

Arthritis	Angina	ALLERGY TO:
Joint Replacement/Implant	Artificial Heart Valve	Ibuprofen
Organ Transplant	Heart Attack	Aspirin
Asthma - Inhaler Yes or No	Heart Lesions	Tylenol
Emphysema	Heart Murmur	NSAIDS
Respiratory Problems	High Blood Pressure	Penicillin
Easily Winded	Low Blood Pressure	Amoxicillin
Hay Fever/Allergies	Mitral Valve Prolapse	Tetracycline
Chew/Smoke Tobacco	Pacemaker	Erythromycin
Cold Sores/Herpes	Rheumatic Fever	Zithromax
Glaucoma	Heart Disease	Azithromycin
Stroke	Chest Pains	Hydrocodone
Epilepsy	Anemia	Codiene
Dizziness	Hemophilia	Morphine
Fainting	Blood Disease	Barbituates
Head Injuries	Blood Transfusion	Sedatives
Mental Disorders	Blood Clots	Local Anesthetics
Drug/Alcohol Addiction	Excessive Bleeding	Iodine
Kidney Disease	Pain/Noise in Jaw Joints	Sulfa Drugs
Diabetes	Pregnancy: Past or Present	Metals
Liver Disease	Thyroid Problems	Latex Rubber
Jaundice	Frequently Tired	NONE
Hepatitis - A B or C	Recent Weight Loss	Others List Below
Aids/HIV	Swollen Ankles	
Venereal Disease	Stomach Problems	
Sexually Transmitted Diseases	Ulcers	
Cancer	Radiation Treatment	
Growths/Tumors	Chemotherapy	
Leukemia	Other:	
Tuberculosis	None	

Have you taken any bone density medications such as Fosamax, Boniva or another such as these? **Yes or No** If yes, which medication?: _____

Have you ever taken a medication for weight loss such as Fen-Phen or another? **Yes or No**
If yes, which medication?: _____

Current Family Physician: _____ Phone Number: _____

Current Medications: _____
