

PATIENT INFORMATION

PATIENT'S NAME Last First Middle Initial SEX: M F BIRTHDATE AGE Soc. Sec. # If Patient is a Minor, give Parent's or Guardian's Name TODAY'S DATE Who May We Thank for Referring You to our Office? Reason for this Visit

RESPONSIBLE PARTY INFORMATION

NAME Last First Middle Initial MARITAL STATUS RESIDENCE Street Apt. # City State Zip MAILING ADDRESS Street Apt. # City State Zip HOW LONG AT THIS ADDRESS HOME PHONE CELL PHONE WORK PHONE E-MAIL PREVIOUS ADDRESS (if less than 3 yrs.) Street City State Zip How Long SOCIAL SECURITY # BIRTHDATE DRIVER'S LICENSE # RELATION TO PATIENT EMPLOYER OCCUPATION NO. YEARS EMPLOYED

RESPONSIBLE PARTY'S SPOUSE

NAME LAST FIRST MIDDLE EMPLOYER OCCUPATION SOC. SEC. # BIRTHDATE HOME PH. CELL PH. WORK PH. E-MAIL

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME RELATIONSHIP ADDRESS CITY, STATE HOME PH. CELL PH. WORK PH.

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name Insurance Co. E-MAIL Insurance Co. Address Insured's Employer Insured's Soc. Sec. # Group # Local #

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name Insurance Co. E-MAIL Insurance Co. Address Insured's Employer Insured's Soc. Sec. # Group # Local #

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY YES NO *MEDICAL HISTORY* YES NO HOW LONG SINCE you have seen a dentist? Do you have any CURRENT HEALTH PROBLEMS? Last COMPLETE Dental Exam, Date: Are you under a PHYSICIAN'S CARE now? Last FULL MOUTH X-RAYS, DATE:(16 Small Films or Panoramic) For what? Are you having PROBLEMS now? What MEDICATIONS are you currently taking? WHAT? Have you ever taken Fen-Phen/Redux? Are you PREGNANT? Are you UNHAPPY with your dentures? Do you use cigars/cigarettes, pipe or chewing tobacco? (circle) Would you like to know more about PERMANENT REPLACEMENTS? PLEASE YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE: Are you APPREHENSIVE about dental treatment? Are you aware of GRINDING or CLENCHING your teeth? Do you have HEADACHES, EARACHES, or NECK PAINS? Have you worn BRACES on your teeth (ORTHODONTICS)? Do you have DISCOLORED teeth that bother you? Would you like your smile to LOOK BETTER or DIFFERENT? Do you REGULARLY use DENTAL FLOSS? Name of Previous Dentist: City: State: How do you feel about your teeth? Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment. FEAR of pain # LACK of concern # COST of treatment # MISSING work time # ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS? Aspirin Local Anesthetic Erythromycin Latex (balloons, gloves, etc.) Nitrous Oxide Codeine Penicillin Are you aware of being allergic to any other medications or substances? If yes, please list: Is there any other Medical or Dental information that you feel I should know about? FAMILY PHYSICIAN PHONE E-MAIL