PERSONAL INFORMATION

Name: _____ Preferred Name: _____
Birth Date: _____ / _____ / _____ Email: _____
Address: _____ (City, State, Zip) _____
Phone: (Home) _____ (Work) _____ (Cell) _____
Emergency Contact (Name & Number) _____

INSURANCE INFORMATION

Dental Insurance ☐ Yes ☐ No Employer _____
Name of Insured _____ Insured DOB _____
Name of Insurance Company_____ Group No._____
Ins. Company Phone # _____ SSN _____ Sub ID No_____

Secondary Insurance ☐ Yes ☐ No Employer _____
Name of Insured _____ Insured DOB _____
Name of Insurance Company_____ Group No._____
Ins. Company Phone # _____ SSN _____ Sub ID No_____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit_____
Have you had and/or currently have any of the following:

☐ Bad breath	☐ Bleeding gums	☐ Braces
☐ Broken/chipped teeth	☐ Clicking/Popping Jaws	☐ Dry Mouth
☐ Grinding your teeth	☐ Implants	☐ Loose teeth
☐ Lost filling	☐ Mouth surgery	☐ Partials/Dentures
☐ Periodontal/gum treatment	☐ Sensitive teeth	

Do you require Antibiotics before Dental treatment? ☐ Yes ☐ No
How would you describe your current dental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
What, if anything, would you change about your smile? _____

HEALTH HISTORY

Physician's Name _____ Date of Last visit? _____
Are you currently under care of a Physician? ☐ Yes ☐ No
Have you had any serious illness, surgeries or hospitalizations?
☐ Yes ☐ No If yes, please describe? _____
Are you currently on or have taken a blood thinner medication?

_____

Patient's Signature Date

⟦⟧ Yes ⟦⟧ No If yes, please list? _____

Have you ever taken any Bisphosphonates drugs, such as Fosamax, Actonel, or Zoledronate?

⟦⟧ Yes ⟦⟧ No If yes, please list? _____

Do you use tobacco? ⟦⟧ Yes ⟦⟧ No Do you consume alcohol? ⟦⟧ Yes ⟦⟧ No

ALLERGIES

Do you have any allergies to the following?

Penicillin ⟦⟧ Yes ⟦⟧ No Latex ⟦⟧ Yes ⟦⟧ No Sulfa ⟦⟧ Yes ⟦⟧ No

Clindamycin ⟦⟧ Yes ⟦⟧ No Local Anesthetic ⟦⟧ Yes ⟦⟧ No Other ⟦⟧ Yes ⟦⟧ No

Erythromycin ⟦⟧ Yes ⟦⟧ No Barbiturates ⟦⟧ Yes ⟦⟧ No

Medications:_____

_____

CONDITIONS

Do You Currently Have Any of the Following?

Alzheimer's	❑ Yes	❑ No	HIV/AIDS	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Headaches	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Heart Surgery History	❑ Yes	❑ No
Anxiety	❑ Yes	❑ No	Hemophilia	❑ Yes	❑ No
Artificial Heart Valve	❑ Yes	❑ No	Hepatitis A, B, or C	❑ Yes	❑ No
Artificial Joints	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Joint Replacement History	❑ Yes	❑ No
Acid Reflux	❑ Yes	❑ No	Kidney Problems	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Liver Problems	❑ Yes	❑ No
Chemotherapy	❑ Yes	❑ No	Osteoporosis	❑ Yes	❑ No
Chest Pain	❑ Yes	❑ No	Pacemaker	❑ Yes	❑ No
Heart Defects	❑ Yes	❑ No	Psychiatric Conditions	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Pregnant/Nursing	❑ Yes	❑ No
Dialysis	❑ Yes	❑ No	Radiation Treatment	❑ Yes	❑ No
Difficulty Breathing	❑ Yes	❑ No	Sinus Problems	❑ Yes	❑ No
Difficult Seeing	❑ Yes	❑ No	Stroke History	❑ Yes	❑ No
Difficulty Hearing	❑ Yes	❑ No	Thyroid Problems	❑ Yes	❑ No
Depression	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Drug Abuse History	❑ Yes	❑ No	Ulcers	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No	Venereal Disease	❑ Yes	❑ No
Epilepsy	❑ Yes	❑ No	Other_____		
Endocarditis History	❑ Yes	❑ No			
Glaucoma	❑ Yes	❑ No			

_____

Patient's Signature Date