Please Print

Patient Information

PATIENT NAME_____

If a child, parent's name_____

Marital Status of Patient: (please circle)

Married / Divorced / Single / Separated / Widowed

Patient's Date of Birth_____Age _____

Patient's SS# _____

Address _____

City _____ State_____ Zip_____

Home Phone # _____

Cel Phone # _____

Business Phone # _____

Email _____

Employer _____

Whom may we thank for referring you to our office? _____

In case of an emergency, who should be notified?
Name _____

Relationship to patient _____

Phone number _____

Dental Insurance

Primary Dental Insurance

Insurance Co Name_____
Insurance Address _____
_____
Insurance Phone # _____
Name of Insured _____
Insured's Birthday _____
Insured's Social Security #_____
Insured's ID # _____
Group Number _____
Insured's Employer _____

Secondary Dental Insurance

Insurance Co Name _____
Insurance Address _____
Insurance Phone # _____
Name of Insured _____DOB_____
Insured's Social Security # _____

Dental Information

Have you ever been told that you meed an antibiotic before dental treatment? ---------- Y / N
If so, for what?
_____

When was your last visit _____

Are you having dental discomfort at this time? ---------- Y / N

Do you have pain in your jaw or near your ears?---------- Y / N

Do you have unhealed injuries or inflamed areas in or around your mouth? ---------- Y / N

Any reaction or allergic symptoms to Novocain, local or general anesthetic? ---------- Y / N

Any difficult extractions in the past? ---------- Y / N

Any prolonged bleeding following extraction in the past? ---------- Y / N

Do your gums bleed? ---------- Y / N

Do you have a bad taste in your mouth or mouth odor? ---------- Y / N

Have you ever had Periodontal (Gum) Treatment? ---------- Y / N

Do you habitually clench or grind your teeth during the day or night? ---------- Y / N

Are any parts of your mouth sensitive to Hot, Cold or Sweets? ---------- Y / N

Do you have dental implants?---------- Y / N

Is there anything about the appearance of your teeth that you would like to change? --------- Y / N
If so, what? _____
_____
_____

Medical Care
Do you have a personal physician? ---------- Y / N
Physician's name _____
Are you presently under your physician's care? ---------- Y / N
If so, for what? _____
Are you taking any medications? ---------- Y / N
Please list (continue on back of page if needed):
_____
_____
_____