Patient Information

Date _____

Patient's Name _____ ☐ Male ☐ Female
Last First Middle

Address _____ Phone _____
Street City State Zip

Birthdate_____ Social Security # _____ 18yrs/older – School Attending _____

If patient is a minor give parent or guardian name _____

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

Responsible Party Information

Name_____ ☐ Single ☐ Married ☐ Divorced ☐ Separated
Last First Middle

Residence _____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____ Email _____

Previous Address (if less than 3 yrs.) _____

Social Security # _____ Birthdate _____

Relationship to Patient: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Legal Guardian ☐ Other _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____
Last First Middle

Relationship to Patient: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Legal Guardian ☐ Other _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Dental Insurance Information

Insured's Name _____ Birthdate _____ Insured's Social Security # _____

Insured's Address _____ Phone _____
Street City State Zip

Relationship to Patient: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Legal Guardian ☐ Other _____

Insurance Carrier_____ Group No. _____ Local No. _____

Insurance Carrier Address _____

Insured's Employer _____

Do you have dual coverage? ☐ Yes ☐ No If yes:

Insured's Name _____ Birthdate _____ Insured's Social Security # _____

Insured's Address _____ Phone _____
Street City State Zip

Relationship to Patient: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Legal Guardian ☐ Other _____

Insurance Carrier_____ Group No. _____ Local No. _____

Insurance Carrier Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____ Relationship _____

Complete Address _____ Phone _____
Street City State Zip

I understand that where appropriate, credit bureau reports may be obtained

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

Name of Patient's Medical Doctor _____

Is patient allergic to (ie: itching, rash, swelling of hands, feet, or eyes) or made sick by penicillin, aspirin, codeine, latex, any drugs or medication? _____

Does patient have any food allergies? _____

Please check any of the following which patient has, or has had.

- ☐ Heart Failure
- ☐ Cough
- ☐ Stroke
- ☐ Angina Pectoris
- ☐ Liver Disease
- ☐ Arthritis
- ☐ HIV, AIDS, or ARC
- ☐ Anemia
- ☐ Scarlet Fever
- ☐ Rheumatic Fever
- ☐ Glaucoma
- ☐ High Blood Pressure
- ☐ Artificial Joint
- ☐ Yellow Jaundice
- ☐ Nervousness
- ☐ Cold Sores
- ☐ Emphysema
- ☐ Asthma
- ☐ Allergies or Hives
- ☐ Hay Fever
- ☐ Thyroid Disease
- ☐ Rheumatism
- ☐ Diabetes
- ☐ Kidney Trouble
- ☐ Heart Pacemaker
- ☐ Heart Murmur
- ☐ Tuberculosis (TB)
- ☐ Heart Surgery
- ☐ Sinus Trouble
- ☐ Drug Addiction
- ☐ Bruise Easily
- ☐ Ulcers
- ☐ Heart Disease or Attack
- ☐ Hepatitis A (infectious)
- ☐ Hepatitis B (serum)
- ☐ X-Ray or Cobalt Treatment
- ☐ Chemotherapy (Cancer, Leukemia)
- ☐ Venereal Disease (Syphilis, Gonorrhea)
- ☐ Fainting or Dizzy Spells
- ☐ Artificial Heart Valve
- ☐ Congenital Heart Lesions
- ☐ Psychiatric Treatment
- ☐ Epilepsy or Seizures
- ☐ Sickle Cell Disease
- ☐ Cortisone Medicine
- ☐ Pain in Jaw Joints
- ☐ Hemophilia
- ☐ Blood Transfusion

Has patient had any other disease or medical condition not listed? ☐ Yes ☐ No What _____

Is patient in the care of a Physician now? ☐ Yes ☐ No What for? _____

Is patient taking any medications? ☐ Yes ☐ No What? _____

Is patient allergic to anything? ☐ Yes ☐ No What? _____

Women only — Is patient pregnant? ☐ Yes ☐ No Months? _____

Has patient ever used phen-fen? ☐ Yes ☐ No When/How long? _____

Does patient have clicking or popping noises when they chew or open their mouth? _____

What is the main reason for your visit today? _____

Date and reason for last dental treatment _____

I authorize the Doctor to examine me (or my child) and obtain necessary diagnostic information.

Signed _____ Date _____

Reviewed Health History _____

Doctor Date