ADULT PATIENT INFORMATION

Date_____

Patient's name_____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address?_____ What is the best time to reach you? _____
Home phone_____ Work phone_____ Cell phone_____

Previous Address (If less than 3 years)_____

Cell Phone_____ Birthdate_____ Social Security # _____

Email Address_____ Marital Status: Single__ Married__ Widowed__ Separated__ Divorced___

Employer_____ Occupation_____ No. years employed _____

Spouse's Name_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Social Security # _____ Birthdate _____ Work Phone_____

Any other family members seen by us? _____

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

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's ID # _____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's ID # _____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

I understand that the information that I have given is correct. I also understand it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

X_____ Date_____

I understand I am responsible for payment of services rendered. If I have insurance I am responsible for any deductibles, and treatment not covered by my dental insurance plan.

X-_____ Date _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have you ever smoked or chewed tobacco? _____
Yes No Have seen a physician in the last 12 months? Why? _____

Female Patients only:

Yes No Have you ever taken Fosmax, or any other biposfosnate? _____
Yes No Are you pregnant? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High/Low Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer
Artificial Bones/Joints/Valves	Frequent Headaches	Seizures	Stroke
Mitral Valve Prolapse	Pace Maker	Liver Disease	Fainting Spells
Difficulty Breathing			

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have your wisdom teeth been removed? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever been told that you snore? _____
Yes No Have you ever been told that you hold your breath while you are sleeping? _____
Yes No Do you ever wake up gasping for breath? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have “tension” headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____
Yes No Are you aware that some appointments will be during work hours? _____

Signature: _____ Date: _____