Whom may we thank for this referral?____

Patient's Name____
Address____
Home Phone________________________ Cell Phone________________________________
Email ______________________________ Birthdate ________________________________
__Male __Female __Married __Single __Divorced__ Widowed
Social Security No. __________________ Occupation________________________________

If Minor, List Parents' Names Father____________________ Mother____________________

Dental Insurance Information (Please provide us with a copy of your insurance card)
Do you have Dental Insurance? Yes or No Name of Insurance Company ________________
Dental Insurance Claims Mailing Address ____
Name of Policy Holder ____
Social Security No. __________________________ Birthdate __________________________
Employer _________________________________ Group No. __________________________
Employer Phone ___________________________ Relationship to patient ________________

Emergency Information
Name ___________________________________ Relationship ________________________
Home Phone _____________________________ Cell Phone___________________________

Getting to Know You
Is another member of your family a patient in our practice? Name ____________________
When was your last dental visit? _____________ When was the last time you had complete dental x-rays? _____________________ Former Dentist: *(Name and phone no.)*
____
Why did you select our office?
____

We are all very pleased to meet you, and look forward to meeting your friends and family.

Medical History

Have you been under the care of a medical doctor during the past two years?_______________
Please explain ____
____
Name of Physician ______________________________Phone No ______________________
Have you ever been hospitalized? ____
Are you allergic to or made sick by: __penicillin __aspirin __codeine __other
please list ____
Have you ever had excessive bleeding requiring special treatment? ___________________

Check any of the following which you have had or have at present:

__Heart Disease or Attack
__Chest Pain
__Tuberculosis (TB)
__Asthma
__Congential Heart Lesions
__Artificial Heart Valve
__Heart Pace Maker
__Heart Murmur/Mitral Valve
__Liver Disease
__Anemia
__Stroke
__Kidney Trouble
__Ulcers
__Shortness of Breath
__Common Cold
__Hepatitis A, B, or C
__Low Blood Pressure
__Hemophilia
__Cold Sores or Fever Blisters
__Hay Fever
__Allergies or Hives
__HIV Positive
__Auto Immune Disease
__Diabetes
__Arthritis
__High Blood Pressure
__Heart Surgery
__Artificial Joint
__Cancer
__Epilepsy or Seizures

Are you having any dental problems at this time? Yes or No
If yes please explain____
Do you feel very nervous about having dental treatment? Yes or No
Do you take any pre-medication before dental treatment? Yes or No
If yes, what do you take? ___________________________
List all medications you are taking at this time. ____
____
Are you a smoker or chew tobacco? Yes or No
Do you have trouble getting numb for dental work? Yes or No
Women: Are you pregnant? Or could you be Pregnant? Yes or No
Do you have any disease, condition or problem not listed? Yes or No
If Yes, please explain ____

How do you feel about getting and maintaining a healthy mouth? _______________________________

How do you feel about the appearance of your teeth? ____

If you could change anything about your smile, what would you change? __________________________
____