Welcome

Please tell us about yourself:

Patient's first and last name:_______________________ Home Phone: (   )___________________
Mailing Address:____
City/State/Zip Code: _______________________________ Date of Birth:____________________
Social Security Number:____________________ Employer:________________________________
Work Phone: (   )______________________ Cell Phone: (   ) __________________________
Email:__________________________________ Receive Text Messages from Office? Yes__ No__
Name of Spouse:__________________________ Spouse Employer___________________________
Spouse Date of Birth: ______________________ Spouse SS#:________________________________

Insurance:

Do you have dental insurance? Yes___ No___
Is the policy in : Your name____ Spouse____ Other____
Please provide the following information for the policy holder:

Name:______________________________ D.O.B.:______________ SS#:______________________
Insurance Company Name:____
Insurance Company Address:____
Phone #: (   )___________________ Group #_________________ ID#:_______________________

Miscellaneous:

How did you hear about us?
Savings Safari_______ ValPak_______ Friend/Relative name_______________________________
Driver's Liscense #:____
Emergency Contact Information:
Name:____________________________________ Phone (   )___________________________
List any medications you are taking: ____
Personal Physician:______________________________ Date of Last Visit:____________________

Do you have or have you had any of the following

Yes	No	
___	___	Heart Trouble
___	___	High Blood Pressure
___	___	Low Blood Pressure
___	___	Epilepsy
___	___	Hepatitis A, B, or C (circle one)
___	___	Diabetes
___	___	Cancer or Radiation Treatment
___	___	Excessive Bleeding
___	___	Nervous Disorders
___	___	Liver Problems
___	___	Anemia
___	___	Rheumatic Fever
___	___	Heart Murmur
___	___	Venereal Disease
___	___	Parkinsons Disease
___	___	Ulcers
___	___	Stroke
___	___	Tuberculosis (T.B.)
___	___	HIV (AIDS)
___	___	Artificial Bones/Joints
___	___	Mitral Valve Prolapse
___	___	Fever Blisters (Herpes 1)
___	___	Blood Transfusion
___	___	Systemic Lupus Erythematosus
___	___	Shunt
___	___	Kidney Problems
___	___	Bacterial Endocarditis
___	___	Are you currently pregnant?
___	___	Are you taking birth control?
___	___	Other

Are you allergic to any of the following:

Yes	No	
___	___	Aspirin
___	___	Barbiturates
___	___	Codeine
___	___	Erythromycin
___	___	Latex
___	___	Metals, please list: ____________ ______________________________
___	___	Penicillin
___	___	Sulfonamides
___	___	Tetracycline
___	___	Other, please list: _________________ __________________________________ __________________________________

Yes	No	
___	___	Have you lost or removed any teeth?
___	___	Have they been replaced?
		How have they been replaced?
		Fixed Bridge _________ age _____
		Removable Partial _____ age _____
		Full Denture _________ age _____
___	___	Are you happy with the replacement?
___	___	Do you clench or grind your teeth?
___	___	Does your jaw click or pop?
___	___	Do your gums bleed or hurt?
___	___	Are you happy with the appearance of your teeth?
___	___	Do you feel your breath is offensive at times?
___	___	Have you ever had gum treatment or surgery?

Reason for dental visit:

____

____

____

When was your last dental visit?

____

When was your last dental cleaning?

____

Do you use dental floss?

___ Yes ___ No