MAIN STREET DENTAL AT 1910
SERVING THE COMMUNITY SINCE 1888

Today's Date_____

Patient's Name_____ Date of Birth_____
LAST FIRST INITIAL

If Child: Parent's Name_____ Patient's Age_____ ☐ Male ☐ Female

Preferred Name _____

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor ☐

Patient is ☐ Policy Holder ☐ Responsible Party ☐ Other

PATIENT INFORMATION

Home Address_____

City_____

State_____ Zip Code_____

Home Phone_____

Cell Phone_____

Business Phone_____

Best Phone for Messages ☐ Home ☐ Cell ☐ Business

Email Address_____

Social Security #_____

Drivers License#_____ State _____

RESPONSIBLE PARTY (If someone other than patient)

Name_____

Home Address_____

City_____

State_____ Zip Code_____

Home Phone_____

Cell Phone_____

Business Phone_____

Best Phone for Messages ☐ Home ☐ Cell ☐ Business

Email Address_____

Social Security #_____

Drivers License#_____ State _____

☐ Responsible party is also a policy holder for patient

☐ Primary insurance policy holder

☐ Secondary insurance policy holder

PATIENT REGISTRATION

EMPLOYER INFORMATION

Employment Status ☐ Employed ☐ Retired ☐ Student

Patient/Parent Employed by_____

Position_____ How Long _____

Employer Address_____

City_____

State_____ Zip Code_____

Spouse Employed by_____

Position_____ How Long _____

Employer Address_____

City_____

State_____ Zip Code_____

PRIMARY INSURANCE INFORMATION

Name of Insured_____

Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Date of Birth _____

Social Security # _____

Insurance Company_____

Address_____

City_____

State_____ Zip Code_____

Policy #_____ Group#_____

SECONDARY INSURANCE INFORMATION

Name of Insured_____

Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Date of Birth _____

Insurance Company_____

Address_____

City_____

State_____ Zip Code_____

Policy #_____ Group#_____

MEDICAL HISTORY

MAIN STREET DENTAL AT 1910
SERVING THE COMMUNITY SINCE 1888

Today's Date_____

Patient's Name_____ _____

_____ Date of Birth_____
LAST FIRST INITIAL

AIDS/HIV/Positive	○ Yes ○ No	Hemophilia	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Hepatitis A	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No
Anemia	○ Yes ○ No	Herpes	○ Yes ○ No
Angina	○ Yes ○ No	High Blood Pressure	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Hive or Rash	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Hypoglycemia	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No
Asthma	○ Yes ○ No	Kidney Problems	○ Yes ○ No
Blood Disease	○ Yes ○ No	Leukemia	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Liver Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Lung Disease	○ Yes ○ No
Cancer	○ Yes ○ No	Mitral Valve Prolapsed	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No
Chest Pains	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Psychiatric Care	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Convulsions	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Cortisone Medicine	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Diabetes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Drug Addiction	○ Yes ○ No	Rheumatism	○ Yes ○ No
Easily Winded	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Emphysema	○ Yes ○ No	Shingles	○ Yes ○ No
Epilepsy or Seizures	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Excessive Bleeding	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Excessive Thirst	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Fainting Spells/Dizziness	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Frequent Cough	○ Yes ○ No	Stroke	○ Yes ○ No
Frequent Diarrhea	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Frequent Headaches	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Genital Herpes	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Glaucoma	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Hay Fever	○ Yes ○ No	Tumors of Growths	○ Yes ○ No
Heart Attack/Failure	○ Yes ○ No	Ulcers	○ Yes ○ No
Heart Murmur	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Heart Pace Maker	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No
Heart Trouble/Disease	○ Yes ○ No		

I certify that the above information is complete and accurate

Are you under a physician's care? ○ Yes ○ No
If yes, explain_____
_____
Physician' name_____
Phone number_____
Have you ever been hospitalized for a major operation or serious illness? ○ Yes ○ No
If yes, explain_____
_____
Have you ever had a serious neck injury?
○ Yes ○ No If yes, explain_____
_____
Are you taking any medications, pills , or drugs?
○ Yes ○ No If yes, explain_____
_____
_____
_____
_____
Do you take , or you have you taken Phen Fen, or Redux? ○ Yes ○ No
Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment for bone tumors, excessive calcium in your blood or osteoporosis? ○ Yes ○ No
Do you have any artificial joints/prosthesis?
○ Yes ○ No If so when?_____
Are you on a special diet? ○ Yes ○ No
If yes, explain_____
_____
Do you use tobacco? ○ Yes ○ No
Do you use controlled substances? ○ Yes ○ No
Are you allergic to the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other Explain_____
_____
Are you pregnant or suspect you might be **(Women)**
○ Yes ○ No
Are you taking birth control? **(Women)**
○ Yes ○ No

Patient's / Guardian's signature_____ Date_____

Doctors Signature _____ Date _____

DENTAL HISTORY

MAIN STREET DENTAL AT 1910
SERVING THE COMMUNITY SINCE 1888

Today's Date_____

Patient's Name_____ Date of Birth_____

Purpose of visit?_____

Are you aware of a problem?_____

How long since your last dental visit?_____What was done at that time?_____

Previous Dentist's Name_____ Phone#_____

Address_____ City_____ State_____ Zip Code_____

When was the last time your teeth were professionally cleaned?_____

Have you had regular dental care? ○ Yes ○ No How often?_____When your last dental x-rays taken?_____

Have you ever had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? Explain:

_____

ADULTS—12YEARS AND OLDER:

Do you clench your teeth? ○ Yes ○ No

Does your jaw click or pop? ○ Yes ○ No

Do your gums hurt or bleed? ○ Yes ○ No

Do you experience dry mouth? ○ Yes ○ No

Have you ever had gum treatment surgery? ○ Yes ○ No

Have you every had orthodontic work? ○ Yes ○ No

Does food get caught in your teeth? ○ Yes ○ No

Are your teeth sensitive to: ○ Hot ○ Cold ○ Sweets ○ Pressure

Have you experienced any pain or soreness in the muscle of your face or around your ear? ○ Yes ○ No

Do you have frequent headaches, neck aches or shoulder aches? ○ Yes ○ No

CHILDREN—12 YEARS AND YOUNGER:

Is this your child's first visit to a dentist? ○ Yes ○ No

How does your child receive Fluoride? ○ Community Water: level____ ppm ○ Well Water: level___ ppm
○ Fluoride drops or tablets ○ Fluoride rinse or gel

Have cavities been noted in the past? ○ Yes ○ No

Were any teeth (baby or permanent) removed by extraction? ○ Yes ○ No

Have there been any injuries to teeth, such as falls, blows, chips etc? ○ Yes ○ No

Has anyone in the family, including parents, had orthodontics? ○ Yes ○ No

Has your child ever received a local anesthetic? ○ Yes ○ No

Has your child ever had occlusal sealants? ○ Yes ○ No

Does your child think there is anything wrong with their teeth? ○ Yes ○ No

I certify that the above information is complete and accurate

Patient's / Guardian's signature_____ Date _____

Doctors Signature _____ Date _____

Main Street Dental at 1910
Donald Compton, DMD
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