Patient Name: Account #: Patient Code: Date:

Patient, Pharmacy and Insurance Information

Patient Information

Prefix: _____ First Name: _____ Middle Name: _____ Last Name: _____

Suffix: _____

Street: _____ Zip: _____ City: _____ State: _____ Country: _____

Preferred Phone #: _____ Is this a mobile number? Yes ☐ No ☐

Email Address: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female ☐ Unspecified

Emergency Contact: _____ Emergency Phone #: _____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Responsible Party

First Name: _____ Middle Name: _____ Last Name: _____

Street: _____ Zip: _____ City: _____ State: _____ Country: _____

Date of Birth: _____ Sex: ☐ Female ☐ Male ☐ Unspecified

Responsible Party Signature: _____ Date: _____

Preferred Pharmacy

Name: _____ Phone Number: _____

Street: _____ Zip: _____ City: _____ State: _____

Primary Dental Insurance

Is subscriber the same as patient? ☐ Yes ☐ No

Subscriber Information:

First Name: _____ Middle Name: _____ Last Name: _____

Employer Name: _____ Insurance Company: _____

Ins Phone Number: _____

Subscriber ID/Policy Number: _____ Group/Contract Number: Date of Birth:

Patient Relationship to Subscriber: ☐ Child ☐ Disabled Dependent ☐ Husband ☐ Self ☐ Wife ☐ Other Dependent

Subscriber SSN: _____

Secondary Dental Insurance

Is subscriber the same as patient? ☐ Yes ☐ No

Subscriber Information:

First Name: _____ Middle Name: _____ Last Name: _____

Employer Name: _____ Insurance Company: _____

Ins Phone Number: _____

Subscriber ID/Policy Number: _____ Group/Contract Number: _____ Date of Birth: _____

Patient Relationship to Subscriber: ☐ Child ☐ Disabled Dependent ☐ Husband ☐ Self ☐ Wife ☐ Other Dependent

Subscriber SSN: _____

Patient Name: Account #: Patient Code: Date:

Health History

Reason for Visit: ☐ Broken Tooth ☐ Check-up ☐ Cosmetic ☐ Dentures ☐ Tooth Pain ☐ Other: _____
Height: _____ ft _____ in Weight: _____ Patient Date of Birth: _____
Are you under the care of a primary physician? ☐ Yes ☐ No
Primary Physician's Name: _____ Physician's Phone Number: _____
Date of Last Physical:
☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: _____
Are you taking or have you taken any steroid/cortisone therapy in the last 2 years? ☐ Yes ☐ No
Have you ever been hospitalized? ☐ Yes ☐ No
Are you taking or have you taken Oral Bisphosphonates (e.g., FOSAMAX, BONIVA) or IV Bisphosphonates, (e.g., ZOMETA, AREDIA)?
☐ No ☐ Yes How Long? _____
Do you require antibiotics prior to dental procedures? ☐ Yes ☐ No
Are you allergic or have you had an adverse reaction to any of the following?
☐ **None** ☐ Amoxicillin ☐ Aspirin ☐ Codeine ☐ Epinephrine ☐ Latex ☐ Metals ☐ Novocain ☐ Penicillin ☐ Sulfa ☐ Tetracycline
☐ Other: _____

List any medications you are taking including non-prescription drugs and herbals/vitamins:
☐ **None**

Check any conditions that apply to you:

☐ **None**
☐ Alcoholism
☐ Allergies or Hives
☐ Anemia
☐ Arthritis
☐ Artificial Joint/Pins
Type: _____
Age: _____
☐ Aspirin Therapy
☐ Asthma
☐ Blood Thinners
☐ Blood Transfusion
☐ Breathing Problems
☐ Cancer
Type: _____
☐ Chemotherapy
☐ Coumadin Therapy
☐ Dementia
☐ Diabetes
Type: _____
☐ Dialysis
☐ Drug Addiction
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting/Dizziness
☐ Hearing Impairment
☐ Heart Murmur
☐ Heart Surgery
Date: _____
☐ Heart Trouble
Type: _____
☐ Hepatitis
Type: _____
☐ High Blood Pressure
☐ HIV
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease/COPD
☐ Lupus
☐ Mitral Valve Prolapse
☐ Mobility Impairment
☐ NON-DENTAL Implants
Type: _____
☐ Organ Transplants
Type: _____
☐ Pace Maker
☐ Psychiatric Care
☐ Radiation Therapy
☐ Radiosurgery
☐ Rheumatic Fever
☐ Seizures
☐ Sexually Transmitted Disease
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis(TB)
☐ Ulcers
☐ Visual Impairment
☐ Other Disease/Illness
Type: _____

Patient Name: Account #: Patient Code: Date:

Dental History

Date of Last Dental Visit:

☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: _____

Date of Last Dental X-ray:

☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: _____

Oral Health

Have you ever been treated for periodontal (gum) disease? ☐ Yes ☐ No

Have you ever had Novocaine or other local anesthetic? ☐ Yes ☐ No

How happy are you with your smile (1-10)? _____

Are you currently wearing Dentures? ☐ Yes ☐ No

Age of dentures: ☐ Less Than 6 Months ☐ 6 months-3 years ☐ Greater than 4 years

Please check any conditions that apply to you below:

☐ Pain In Jaw(TMJ) ☐ Teeth Grinding/Clenching ☐ Use Tobacco Products ☐ Mouth Sores

☐ Sensitive Teeth ☐ Broken/Loose Teeth ☐ Difficulty Chewing/Swallowing ☐ Swollen/Bleeding Gums

Women Patients Only

Are you currently pregnant? ☐ Yes ☐ No Estimated Delivery Date: _____

Are you Nursing? ☐ Yes ☐ No Are you taking any birth control prescriptions? ☐ Yes ☐ No

**NOTE Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature: _____ Date: _____

Dr's Signature/Medical History Review: _____ Date: _____

6 MONTH UPDATE

Patient's Signature: _____ Date: _____

Dr's Signature/Medical History Review: _____ Date: _____