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**Patient Information:**
Patient Name: _____ Preferred Name: _____

Birth Date: _____ Male: _____ Female: _____ Married: _____ Single: _____ Minor: Yes No

SS#: _____ Driver's License #: _____

Address: _____ City: _____State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

E-mail address: _____

Best way to reach you: _____

Employer: _____

Emergency Contact: _____ Phone #: _____

Other family members seen by us: _____
How did you hear of us? _____
If referred by someone, whom may we thank for the referral? _____

Parent/Guardian Information (if patient is a minor): Name: _____
Relationship to patient: _____ Birth Date: _____
SS#: _____ Driver's License #: _____

***If Address is not the same***
Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

**Dental Insurance Information (Primary):**
Policyholder's Name: _____ Birth Date: _____ SS#: _____
Insurance Company: _____ Group #: _____
Employer: _____ Policyholder's ID#: _____
Patient Relationship to Policyholder: Self _____ Spouse _____ Child _____ Other _____

**Dental Insurance Information (Secondary):**
Policyholder's Name: _____ Birth Date: _____ SS#: _____
Insurance Company: _____ Group #: _____
Employer: _____ Policyholder's ID#: _____
Patient Relationship to Policyholder: Self _____ Spouse _____ Child _____ Other ____

Do you like your smile? Yes No
What, if anything, would you change about your smile? _____
Why have you come to the dentist today? _____

Are you currently in pain? Yes No Do your gums bleed? Yes No
How many times a day do you brush? _____
Do you now have or have you ever experienced pain/discomfort in your jaw (TMJ)? Yes No

Have you ever had problems with previous dental treatment? Yes No
If yes, please explain: _____

Previous Dentist or Dental Office: _____
When was last dental visit? _____

Do you smoke or use chewing tobacco? Yes No
If yes, how long? _____ How often? _____

Physician's Name: _____ Phone #: _____
Have you ever had a serious head, neck, or back injury? _____

**WOMEN:**
Are you or could you be pregnant? Y N
Are you nursing? Y N
Taking Oral Contraceptives? Y N

***Are you currently being treated for or have you ever been treated for any of the following? Please circle all that apply:***

| | | | | | |
|---|---|---|---|---|---|
| Rheumatic Fever | Low Blood Pressure | HIV/AIDS | Sinus Problems | Cancer/Chemo | Excessive bleeding/Bruise easily |
| Epilepsy/Seizures | High Blood Pressure | Mitral Valve Prolapse | Blood Transfusion | Heart Murmur | Any implant/transplant |
| Tuberculosis | Diabetes | Glaucoma | Heart Attack/Stroke | Psychiatric Care | Kidney Problems |
| Hepatitis | Asthma | Artificial Valve/Joint | Arthritis | Pacemaker | Severe Headaches |
| Drug/Alcohol Abuse | Thyroid problems | Heart surgery | Autism | | |

Please list any medical condition not listed above: _____

**Are you allergic to any of the following? PLEASE CIRCLE Y (YES) or N (NO) FOR EACH ONE**.

**Latex** Y N **Penicillin** Y N **Aspirin** Y N **Erythromycin** Y N **Codeine** Y N **Tetracycline** Y N **Ibuprofen** Y N
**Tylenol** Y N **Sulfa** Y N **Dental Anesthetics** Y N **Other** _____
**Please list all medications you are currently taking (or if you have a list please provide us a copy):**
_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my medical status.
Patient Signature: _____ Date: _____

Parent/Guardian Signature if patient is a minor: _____ Date: _____