General Information

Name: ____ Preferred Name: ___________________

Social Security #:___________________________________

Address: ______________________________________ City: _________________ State: ________

Zip Code: _____________ Phone Number to confirm appointments:________________________

Home Phone: __________________ Cell: __________________Work:______________________

Male: ______ Female: ______ Age: _____Birthdate: ______________
Single: _______ Married: _______ Widowed: _______ Separated: _______ Divorced: _______

E-Mail Address: ____________________________Employer:__________________________________

Notify in case of emergency: ________________________ Phone: ____________ Cell: ____________
Relationship: ____________________

Is the patient a dependent? _________**If yes, please fill out Guardian information.**
Guardian: Name: _________________________________ Social Security #:____________________
Address (If different from above): ____
Phone: ___________________ Cell: ___________________ Work: ___________________
Birthdate: _____________

Insurance

Subscriber Name:________________________________ Social Security #: __________________
Subscriber Birthdate:________________ Relationship to the patient: _______________________
Employer:______________________________ Employer Phone:__________________________
Insurance Company:___________________________________ Phone:_____________________
Group Number:______________________ Subscriber ID Number:__________________________
Other dependents on this plan:____

Is the patient covered by additional insurance? Yes ______ No ______
If yes, please list information below:
____
____
____
____

Circle any of the following that apply:

Bad Breath	Food packing between teeth	Gum Disease	Sensitivity to Sweets
Bleeding Gums	Grinding/Clenching teeth	Sensitivity to Cold	Sensitivity to Hot
Jaw pain	Loose teeth	Broken Fillings	Sensitivity to Biting

Do you smoke or use any tobacco products? _________ Amount:__________________________
How often do you brush per day? ______________How often do you floss? ________________
If you could change anything about your smile, what would it be?__________________________
____
Have you ever had any adverse reaction to any dental treatment in the past?________________
____
Do you need to be sedated for dental appointments? ____________________________________
Have you ever had to pre-medicate for dental appointments in the past? ___________________

Height:____________ Weight____________

OFFICE USE ONLY- MEDICAL ALERTS

OFFICE USE ONLY- BLOOD PRESSURE

Circle all that apply:

High blood pressure	Heart attack	Food allergies	Liver disease
Low blood pressure	Heart surgery	Anaphylaxis	Kidney disease
Anemia	Heart Stents	Headaches	Colitis / stomach ulcer
Hemophilia	Mitral valve prolapse	Stroke	Cancer
Abnormal bleeding	Rheumatic fever	Seizures	Radiation therapy
Sickle cell disease	Seasonal allergies	Alcohol or drug abuse	Chemotherapy
Blood disease	Asthma	Psychiatric problems	Artificial joints or bones
Circulatory problems	Difficulty breathing	Fainting	Back problems
Artificial heart valve	Emphysema	Glaucoma	Taken bone density drugs
Pacemaker	Tuberculosis	Thyroid Disease	Shingles
Heart problems	Sleep Apnea	Diabetes	Arthritis
Angina	Material allergy (latex, metal)	Hepatitis A, B, C	Venereal disease
			AIDS/HIV+

Other medical conditions:____
Physician's name:_______________________________________ phone:___________________
Date of last physical: _________________ Are you currently under physician's care:_________
Have you ever had a blood transfusion? _________ Date: _________
Are you pregnant? _________ Due Date: __________ Are you taking birth control? ________
(pills, shot, implant, etc.)

List current medications you are taking:

List allergies, if any:____

*PATIENT OR GUARDIAN SIGNATURE*____*DATE*_________________