

# PATIENT INFORMATION FORM

(PLEASE PRINT)

Today's Date: \_\_\_\_\_

Patient's Full Name: \_\_\_\_\_

Name Preferred To Be Called By Our Staff: \_\_\_\_\_

Patient's Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Email Address: \_\_\_\_\_

Married \_\_\_ Single \_\_\_ Widowed \_\_\_ Divorced \_\_\_ Male \_\_\_ Female \_\_\_

Spouse's Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Spouse's Business Phone #: \_\_\_\_\_

Can Calls Be Received At Work? \_\_\_\_\_

Person Responsible For Account Payment: \_\_\_\_\_

Relationship To Patient: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer of Above: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Phone #: \_\_\_\_\_

Can Calls Be Received At Work?: \_\_\_\_\_

Dental Insurance: YES \_\_\_ NO \_\_\_ Two Companies: YES \_\_\_ NO \_\_\_

Insurance Company Name: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Subscriber's DOB: \_\_\_\_\_ Subscriber's SSN: \_\_\_\_\_

Payment Method: Cash/Check \_\_\_ VISA/MC \_\_\_

Discover \_\_\_ Care Credit \_\_\_

Emergency Contact: Family Member or Close Friend (Not Living With You):

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Whom May We Thank For Referring You: \_\_\_\_\_

(OVER)

## DENTAL HISTORY

What Is The Purpose Of Your Visit? \_\_\_\_\_  
 Approx Date Of Last Dental Visit & Purpose: \_\_\_\_\_  
 Reason For Leaving Previous Dentist? \_\_\_\_\_  
 Have You Ever Had Periodontal (Gum) Treatment? \_\_\_\_\_  
 Do Your Gums Bleed, Feel Tender, or Irritated? \_\_\_\_\_  
 Approx Date Of Your Last Exam/Cleaning: \_\_\_\_\_  
 How Often Do You Brush Your Teeth? \_\_\_\_\_  
 Do You Floss? \_\_\_\_\_ How Often? \_\_\_\_\_  
 Would You Be Interested In Whiter & Brighter Teeth? \_\_\_\_\_  
 Are You Concerned With Bad Breath? \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name: \_\_\_\_\_  
 Are You Under A Physician's Care? \_\_\_\_\_  
 If Yes, Please Explain: \_\_\_\_\_  
 Have You Ever Been Hospitalized, Had Major Surgery, Serious Illness? \_\_\_\_\_  
 If Yes, Please Explain: \_\_\_\_\_  
 Please List Medications You Are Taking & Reason For Each: \_\_\_\_\_  
 \_\_\_\_\_  
 Have You Ever Had Any Unusual Reactions To A Drug Or Anesthetic? \_\_\_\_\_  
 (Ex: Penicillin, Codeine, Aspirin, Etc.)? \_\_\_\_\_  
 Are You Allergic To Latex? \_\_\_\_\_  
 Are You Allergic To Any Metals (Costume Jewelry, etc.)? \_\_\_\_\_  
 Do You Have Trouble With Prolonged Bleeding After Surgery, With A Cut, Or After  
 A Tooth Extraction? \_\_\_\_\_  
 Are You HIV Positive? \_\_\_\_\_  
 Do You Have Any Intravenous Devices (Ex: PICC Line, Portacath, CSF Shunt or Hickman Catheter)?  
 \_\_\_\_\_  
 Are You On Dialysis? \_\_\_\_\_  
 Do You Have Any Joint Implants, Donor Organs, Artificial Valves/Vessels, Or Use A Pacemaker?  
 \_\_\_\_\_  
 WOMEN: Is There A Possibility That You Could Be Pregnant? \_\_\_\_\_  
 Estimated Due Date: \_\_\_\_\_  
 Are You Taking Birth Control Pills? \_\_\_\_\_

Do You Have Or Ever Had The Following (Please Check):

|                |                         |                     |
|----------------|-------------------------|---------------------|
| AIDS           | Hemophilia              | Nervous Problems    |
| Allergies      | Heart Trouble           | Respiratory Disease |
| Anemia         | Angina                  | Stomach Disease     |
| Asthma         | Infectious Endocarditis | Stroke              |
| Cerebral Palsy | Hepatitis               | Tuberculosis        |
| Diabetes       | High Blood Pressure     | Tumors/Growths      |
| Epilepsy       | Kidney Disease          | Other               |
| Glaucoma       | Liver Disease           |                     |

X \_\_\_\_\_ Date \_\_\_\_\_

I Certify That The Answers Are Correct To The Best Of My Knowledge