Date_____

Confidential Patient Information

Patient's Name _____
Last *First* *Middle* *Age*

Address _____

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Patient's Dentist _____

Whom may I thank for referring you to our office? _____

Confidential Responsible Party Information

Name _____ Marital Status _____
Last *First* *Middle*

Residence _____ ☐ own ☐ rent
Street *City* *State* *Zip*

Mailing Address _____
Street *City* *State* *Zip*

How long at this Address? _____ Home Phone _____ Work Phone _____ Cell _____

Previous Address (If less than 3 yrs.) _____
Street *City* *State* *Zip*

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Policy Holder's Name _____ Insured Identification # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? No Yes If Yes:

Policy Holder's Name _____ Insured Identification # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

I understand that where appropriate, credit bureau reports may be obtained

Signature (Parents signature if minor) _____

Updates (date & Initial) _____

HEALTH QUESTIONNAIRE

Please answer each question. Circle Yes or No where applicable.

MEDICAL HISTORY

1. Is patient in good health? ..... Yes No
2. Is patient presently under the care of a physician? ..... Yes No
   If so, what is the condition being treated _____
3. Has patient ever had any serious illness or operation? ..... Yes No
4. Is patient taking any drugs or medication? ..... Yes No
   If so, what? _____
5. Is patient sensitive or allergic to any drugs? ..... Yes No
   If yes, please indicate which drugs: .....
6. Does patient have tendency to colds, sore throats, ear infections? ..... Yes No
7. Has the patient reached puberty? _____ Yes No
   Menstruated (girls) age _____ or voice changed (boys) age _____
8. Does patient have, or had any of the following: (Please circle known conditions)

Anemia	Blood Diseases	Rheumatism or Arthritis	Epilepsy
Heart Ailments	Hepatitis, Jaundice or Liver Disease	Head Injuries	Mental Disorders
High Blood Pressure	Kidney Disease	Stomach Ulcers	Stroke
Respiratory Tuberculosis	Tumors or Growths	Difficulty in Swallowing	Glaucoma
Nervous Disorder	Radiation Treatment of any kind	Venereal Disease	Herpes
Diabetes	Allergies	Acquired Immune Deficiency	Sinus Trouble
Excessive Bleeding	Asthma or Hay Fever	Other _____	
Rheumatic Fever	Fainting Spells or Seizures	_____	
	Artificial Prosthesis (Implants)	_____	

9. Does patient have any disease, condition, or problem not listed that you think I should know ..... Yes No
   If so, what? _____

DENTAL HISTORY

1. Date of last dental examination? _____
2. Is dental work complete ..... Yes No
3. How often does patient brush teeth? _____ Floss? _____
4. Has patient ever had an injury to face or jaw? ..... Yes No
5. Is patient aware of tooth grinding or clinching habits? ..... Yes No
6. Does patient have any speech problems? ..... Yes No
7. Does patient breathe mostly through the mouth, and/or are lips usually parted? ..... Yes No
8. Has patient ever sucked thumb or finger? ..... Yes No
   If yes, until what age? .....
9. Does orthodontic/dental treatment make you nervous? ..... Yes No
   If yes, circle: slightly moderate extremely
10. Does your jaw make "clicking" or "popping" sounds when you chew? ..... Yes No