

Patient Information

Date: _____

Patient's Name: _____
Nickname: _____
Address: _____
Phone: _____ Age: _____ Birthdate: _____
School: _____ Grade: _____

Responsible Party

Self Father Mother
Stepfather Stepmother Guardian

Name: _____
Address: _____

Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email: _____
Employer: _____
Occupation: _____
of years Empl: _____
Birthdate: _____
Social Security #: _____

Marital Status Single Married Divorced
Widowed Separated

Additional Responsible Party

Father Mother
Stepfather Stepmother Guardian

Name: _____
Address: _____

Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email: _____
Employer: _____
Occupation: _____
of years Empl: _____
Birthdate: _____
Social Security #: _____

Marital Status Single Married Divorced
Widowed Separated

Primary Insurance

Insured's Name: _____
Relationship: _____
Birthdate: _____
Member ID#: _____
Insurance Company: _____
Group #: _____
Ins. Co. Address: _____
Ins. Co. Phone #: _____

Additional Insurance

Insured's Name: _____
Relationship: _____
Birthdate: _____
Member ID#: _____
Insurance Company: _____
Group #: _____
Ins. Co. Address: _____
Ins. Co. Phone #: _____

Authorization and Release

I verify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing the incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature _____ Date: _____

I understand that where appropriate, credit bureau reports may be obtained.
Signature (Parent's signature if minor) _____

Medical and Dental History

Date _____

Patients Name: _____ Date of birth: _____

Yes No

Has patient:

- 1. Seen a physician for routine physical exam?
Physician name: _____
Date of last physical examination: _____
Results: _____
- 2. Ever had a health problem? If yes, explain _____
- 3. Is the patient currently under the care of a physician? If yes, explain _____
- 4. Ever been treated in an emergency room/hospital? Why? _____
- 5. Ever been allergic to anything? What? _____
- 6. Does patient presently take any daily medication? What? _____
- 7. Had any unfavorable reactions to medicine? _____
- 8. Ever had any physical, emotional, mental, or nervous disorders? If yes, explain _____
- 9. Do you wish to discuss any medical conditions with the doctor in private?

Please check if the patient has had any of the following?

- | | | | | | |
|---------|-------------------|---------|----------------------|---------|------------------|
| A _____ | Heart Disease | G _____ | Diabetes | L _____ | Kidney problems |
| B _____ | Rheumatic Fever | H _____ | Asthma | M _____ | Speech problems |
| C _____ | Bleeding problems | I _____ | Epilepsy/convulsions | N _____ | Hearing problems |
| D _____ | Anemia | J _____ | Cleft lip/palate | O _____ | Tonsils removed |
| E _____ | Blood disorders | K _____ | Arthritis | P _____ | Adenoids removed |
| F _____ | Hepatitis | | | | |

- 10. Has any member of your immediate family had problems with any of the above? What? _____
- 11. Has patient ever had a blood transfusion? If yes, explain _____
- 12. Is patient currently pregnant?
- 13. Females: Has menstruation begun?
- 14. Has the patient ever been to a dentist?
If yes, who is the dentist and the date of the last examination: _____

Date of last x-ray films: _____

15. Please check if patient has had any problems with any of the following:

A _____	Cavities	D _____	Color of teeth	G _____	Gum infections
B _____	Toothaches	E _____	Sensitive teeth	H _____	Other problems
C _____	Teeth Bumped	F _____	Bleeding gums		

Comments: _____

_____ 16. Has patient ever had problems with your jaw joint (TMJ)? If yes, explain? _____

_____ 17. Has anyone in the family ever had more or fewer than the normal number of teeth?
If so, which members? _____

_____ 18. Has patient ever sucked his/her finger or thumb? If yes, explain _____

_____ 19. Does patient receive any form of fluoride? If yes, explain _____

_____ 20. Is patient currently or has patient ever been a mouth breather? If yes, explain _____

_____ 21. Has patient inherited any family facial or dental characteristics? If yes, explain _____

22. What is your main concern in seeking this appointment? _____

23. Whom may we thank for referring you? _____

Please complete below growth information if patient is under 18 years of age.

_____ 24. Has your child had any recent rapid growth? If yes, how much. _____

25. Parents: Ht. _____ Wt. _____
Ht. _____ Wt. _____

Patient: Ht. _____ Wt. _____

Brothers and Sisters: Ht. _____ Wt. _____ Sex _____ Age _____

Emergency Information

Name of nearest relative not living with you _____

Complete address _____ Phone _____