## *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. Additionally, I understand that where appropriate, credit bureau reports may be obtained.

Signature ______________________________ Date:______________

## *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 | | | | |

| Yes | No | | |
|---|---|---|---|
| _____ | _____ | 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 ____________________