Dental Patient Information Form

Reason for Today's Visit: _____

Name:_____Sex:_____M_____F

Home Phone:_____Work Phone:_____Cell Phone: _____

How would you like your appointments to be confirmed? Call Text Email

Email Address: _____

Home Address:_____City:_____Zip Code: _____

Patient SS# (required):_____Date of Birth:_____

Driver's License #:_____State:_____Exp. Date: _____

Marital Status: Married Divorced Legally Separated Single

Full Time Student: Yes No Name of School: _____

Nearest relative not living with you:_____Phone: _____

Whom may we contact in the case of an emergency?_____Phone:_____

Whom may we thank for referring you to us?_____

Date of last dental exam: _____

Name of previous treating dentist: _____

Did you sustain an injury at work?
□Yes □No

Are you covered under an employer or union policy?
□Yes □No

Are your injuries accident related?
□Yes □No

Is your spouse or other family member employed?
□Yes □No

Are you currently employed?
□Yes □No

Do you have a secondary or medical insurance policy?
□Yes □No

Dental Insurance Information

Name of Insured:_____

Relationship to Patient: _____

Policyholder Date of Birth: _____

Policyholder SS# (required): _____

Dental Insurance Information

Dental Insurance Carrier Name, Address, Phone #:

_____

Identification card present upon encounter: Yes No

Insured's Employer Name and Address:

_____

_____

Employer Phone#: _____

Are you currently under the care of a physician? _____

Are you allergic to latex? Yes No

Have you been previously diagnosed with sleep apnea? Yes No

Have you been tested for sleep apnea? Yes No

Have you been previously diagnosed with TMJ or TMD? Yes No

Have you received previous treatment for TMJ or TMD? Yes No

Allergies (circle all that apply):

Penicillin/Amoxicillin Latex Aspirin Tetracycline Sulfa Drugs

Other Allergies: _____

Are you taking any of the following (circle all that apply):

Blood Thinners Nerve Pills Pain Killers Muscle Relaxers Insulin Stimulants

Other Medications you are taking: _____

Medical History

Do you have or have had any of the following diseases?

YN Heart Attack/Stroke	YN Thyroid Problems	YN Cancer	YN Cosmetic Surgery
YN Surgery/Pacemaker	YN Kidney Problems	YN Shingles	YN X-ray/Cobalt Treatment
YN Heart Murmur	YN Liver Problems	YN Hepatitis	YN Chemotherapy
YN Rheumatic Fever	YN Respiratory Problems	YN HIV	YN Asthma
YN Mitral Valve Prolapse	YN Sinus Problems	YN Arthritis	YN Difficulty Breathing
YN Artificial Valves	YN Stomach Problems	YN Diabetes	YN Artificial Bones/Joints
YN Heart Disease	YN Psychiatric Problems	YN Leukemia	YN Emphysema
YN Heart Defect	YN Venereal Disease	YN Anemia	YN Fainting/Seizures
YN Chest Pains	YN Alcohol/Drug Abuse	YN Headaches	YN HBP/LBP **(circle one)**
YN Scarlet Fever	YN Tuberculosis	YN Neck Pain	YN Bleeding Problems
YN Nervousness	YN TMJ/TMD	YN Glaucoma	YN Back Problems

Other medical condition(s) you have or have had: _____

_____

Past or Present History of (circle all that apply):

Accidental injury to teeth/mouth	Blisters on lips	Blisters in mouth
Blisters or burning of tongue	Chew on one side of mouth	Clench/ grind teeth
Dental fractures	Dry mouth	Growths/ lesions in mouth
Gums swollen, tender /bleeding	Head, neck, jaw pain,	Lip or cheek biting
Loose teeth or broken fillings	Mouth breathing	Orthodontic treatment
Nitrous Oxide	Periodontal treatment	Sensitivity to hot/cold

How often do you floss? _____

How often do you brush your teeth? _____

Are you in pain at this time? _____

For how long have you been in pain? _____

Is your pain due to an accidental injury or accident? _____

Explain: _____

Women Only:

Are you pregnant? Yes No Nursing? Yes No