Patient Information

Patient Name _____ Preferred Name/Nickname_____

Address_____

City _____ State_____Zip _____ Home Phone _____

Birth Date _____/_____/_____ Age_____ Sex: M /F Height _____ Weight _____

School/Occupation_____ Email Address_____

Are you happy with your smile? **Yes/ No (CIRCLE ONE)**

Are you interested in whitening your teeth? **YES OR NO (CIRCLE ONE)**

How did you hear about our office?_____

Medical Information

Are you currently under the care of a physician Yes/No Name of physician:_____

Phone_____

Does the patient have or has he/she had any of the following conditions? **(CIRCLE Y/N)**

Y/ N Diabetes

Y/ N Stroke

Y/ N Asthma

Y/ N Hepatitis or Liver disease

Y/ N Tonsillitis

Y/ N AIDS, HIV +

Y/ N Cancer/Chemotherapy

Y/ N Stroke

Y/ N Difficulty Breathing

Y/ N Fainting Spells,Seizures

Y/ N Rheumatic/ Scarlet Fever

Y/ N Allergies(Medicine or other)

Y/ N Latex or Nickel Sensitivity/Allergy

Y/ N High or Low Blood Pressure

Y/ N Epilepsy

Y/ N Emphysema

Y/ N Heart Defect, Heart Murmur, Heart Disease

Y/ N Herpes, Fever Blisters

Y/ N Joint Replacement/Implant

Y/ N Drug or Alcohol Dependence

Y/ N Tonsils/Adenoids Removed

Y/ N Anemia

Y/ N Excessive Bleeding/Bruising

Y/ N Hospitalized for any Reason

Do you Smoke or use tobacco in any other form? **Yes/ No**

Do you have any history of substance abuse? **Yes/No**

Do you have any drug allergies? **Yes/ No**

List:_____

Do you take any blood thinners? **Yes/ No**

Do you, now or have ever taken any medications for your bones, Ex: bisphosphonates, Fosamax, Boniva, Actonel, or Zometa? If so, which drug? _____

If female, has she begun menstruating? **Yes/ No** If yes at what age?____yrs

Are you pregnant? **Yes/No** What trimester are you in?_____

Do you have a disease, condition, or problem not listed that you think we should know about?

Please Explain:_____

Are you taking any prescription/ over-the-counter drugs at this time? **Yes/No**

list_____

Dental Health Information

Are you experiencing any dental problems, pain or discomfort? **Yes/ No** Date Of Last Dental visit: _____/_____/_____

Most recent dentist _____ Address _____ Phone_____

Have you ever had a serious/ difficult problem associated with any previous dental work? **Yes/ No**

Do you require antibiotics/premedications before dental treatment? **Yes/ No**

Does the patient have or has he/she had any of the following diseases or problems? **(CIRCLE Y/N)**

Y/ N Tongue Thrust

Y/ N Sore or Bleeding Gums

Y/ N Permanent Tooth Extraction

Y/ N Difficulty Chewing

Y/ N Gum Treatment in the Past

Y/ N Previous Orthodontic Treatment

Y/ N Clicking or Popping of the Jaw Joints

Y/ N Jaw Pain (Joint Ear, Side of Face)

Y/ N Tooth Sensitivity to Heat, Cold or Sweats

Y/ N Any Loose Teeth

Y/ N Extra Permanent Teeth

Y/ N Fear of Dental Work

Y/ N Clenching or Grinding

Y/ N Head/ Neck, Jaw or Tooth Injury

Dental Insurance Information

Primary Insurance Company Name _____ Employer Name _____

Phone # _____ ID#_____

Address_____

Group/Plan Number _____

Primary Policy Holder Name _____Social Security Number _____-_____-_____

Date of Birth _____/_____/_____

Responsible Party Information

Name_____ Phone # _____

Email Address_____ Date of Birth _____/_____/_____

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in the patient's medical status.

Signature of Patient/Guardian _____ Date _____

Doctor's Signature _____Date _____