Today's Date:_____/_____/_____

Patient Information

Patient's Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Age _____ Male☐ Female☐

Address _____ City _____ State _____ Zip _____

Telephone (*Mobile*) _____ (*Home*) _____ (*Work*) _____

How did you hear about our office?_____

Parent/Guardian Information (If Patient is a minor)

Last Name _____ First Name _____ Middle Initial _____

Relationship to Patient _____ Date of Birth _____

Address (*if different*) _____ City _____ State _____ Zip _____

Telephone (Mobile) _____ (*Home*) _____ (*Work*) _____

Email Address _____

Insurance Information

Primary Insurance	Secondary Insurance
Policy Holder Name _____	Policy Holder Name _____
Date of Birth _____	Date of Birth _____
Relationship to Patient Self☐ Spouse☐ Child☐ Other_____	Relationship to Patient Self☐ Spouse☐ Child☐ Other_____
Insurance Company _____	Insurance Company _____
Member ID _____	Member ID _____
Group Number _____	Group Number _____
Employer _____	Employer _____
Insurance Phone Number _____	Insurance Phone Number _____

Emergency Contact Name _____ Relationship _____ Phone _____

Consent for Initial Exam

I consent to the diagnostic procedures necessary to perform an Initial Exam, which may include any necessary radiographs, intra-oral/extra-oral exam.

Signature (*responsible party if patient is a minor*) _____ Date _____

Dental History

Reason for Today's Visit _____

Are you currently experiencing dental pain or discomfort? Yes☐ No☐ (*If yes, Where*)_____

Are there any other concerns we should be aware of?_____

When did you last visit a Dentist? _____

	Yes	No	Don't Know
Do your gums bleed when you brush or floss?.....	☐	☐	☐
Is your Mouth Dry?.....	☐	☐	☐
Do you grind your teeth?.....	☐	☐	☐
Do you wear Dentures or Partials?.....	☐	☐	☐

How do you feel about your smile? _____

Patient's Last Name _____ **First Name** _____ **DOB** ____/____/____ **Today's Date** ____/____/____

Patient Medical History

Are you under the care of a Physician now? Yes☐ No☐ Physician's name _____

Have you every been hospitalized or had a major operation/surgery? Yes☐ No☐

If yes, Please Explain _____

Have you every had a serious head or neck injury? Yes☐ No☐ *If yes, Please Explain* _____

Please list any medications that you are currently taking

Medication	Dosage	How Often	Route (Oral / Injection etc)

Do you use tobacco? (smoking, snuff, chew, bidis) Yes☐ No☐

Do you drink Alcoholic beverages? Yes☐ No☐ If yes, about how many drinks per week? _____

Do you use controlled substances? Yes☐ No☐

Are you Allergic to any of the following? Latex☐ Local Anesthetic☐ Penicillin☐ Aspirin☐ Codeine☐ Metal☐

Sulfa Drugs☐ Acrylic☐ Other_____

Women Only- Are you Pregnant? Yes☐ No☐ Number of weeks_____ Nursing? Yes☐ No☐

Taking birth control pills? Yes☐ No☐

Medical History - *Do you have or have you had any of the following?*

Artificial Heart Valve	Yes☐	No☐	Dizzy / Fainting Spells	Yes☐	No☐	Psychiatric Care	Yes☐	No☐
Artificial Joints	Yes☐	No☐	Down Syndrome	Yes☐	No☐	Rheumatic Fever	Yes☐	No☐
AIDS / HIV	Yes☐	No☐	Emphysema	Yes☐	No☐	Scarlet Fever	Yes☐	No☐
Anemia	Yes☐	No☐	Epilepsy / Seizures	Yes☐	No☐	Shortness of Breath	Yes☐	No☐
Angina / Chest Pains	Yes☐	No☐	Frequent Cough	Yes☐	No☐	Sickle Cell Anemia	Yes☐	No☐
Arthritis, Rheumatism	Yes☐	No☐	Glaucoma	Yes☐	No☐	Sinus Trouble	Yes☐	No☐
Asthma	Yes☐	No☐	Heart Attack / Failure	Yes☐	No☐	Skin Rash	Yes☐	No☐
- (required hospitalization)	Yes☐	No☐	Heart Disease	Yes☐	No☐	Stroke	Yes☐	No☐
Autism	Yes☐	No☐	Heart Murmur	Yes☐	No☐	Swelling of feet or ankles	Yes☐	No☐
Bleeding / Clotting Problems	Yes☐	No☐	Heart Valve Prolapse	Yes☐	No☐	Thyroid Problems	Yes☐	No☐
Blood Disorder	Yes☐	No☐	Heart Pacemaker	Yes☐	No☐	Tonsillitis	Yes☐	No☐
Birth Defect	Yes☐	No☐	Hepatitis (type _____)	Yes☐	No☐	Tuberculosis	Yes☐	No☐
Bronchitis	Yes☐	No☐	Herpes	Yes☐	No☐	Tumor/ growth (head/neck)	Yes☐	No☐
Cancer	Yes☐	No☐	High Blood Pressure	Yes☐	No☐	Ulcers	Yes☐	No☐
Cerebral Palsy	Yes☐	No☐	High Cholesterol	Yes☐	No☐	Unexplained weight loss	Yes☐	No☐
Chemo / Radiation Therapy	Yes☐	No☐	Immune Deficiency	Yes☐	No☐	Any other serious illness not listed above?		
Cold Sores / Fever Blisters	Yes☐	No☐	Jaundice	Yes☐	No☐	_____		
Congenital Heart Disorder	Yes☐	No☐	Kidney Disease	Yes☐	No☐			
Convulsions	Yes☐	No☐	Low Blood Pressure	Yes☐	No☐	_____		
Diabetes	Yes☐	No☐	Osteoporosis / Osteopenia	Yes☐	No☐			

The Information I have given is correct to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes in my/my child's health and/or medications. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me/my child. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

Patient's Signature _____ Date _____/_____/_____

(Parent / Legal Guardian if Patient is a minor)