Patient Form

About You:

Date: _____

Patient Name: _____ Preferred to be called: _____

Male: _____ Female: _____ Birth date: M _____ D _____ Y _____

Mailing Address: _____

_____

Home phone: _____ Work phone: _____ Extn: _____

Cell phone: _____ Email Address: _____

Referred by: _____

Employer: _____

Employer Address: _____

Occupation: _____ Status: Minor___Single ___Married___Divorced___Widowed___

Spouse's name: _____

Primary Dental Insurance:

Co. name: _____

Address: _____

_____

Phone #: _____ Insured's ID #: _____

Group # (Plan, Local, or Policy #): _____

Insured's name: _____ Relation: _____

Date of Birth: _____ Insured's Employer: _____

Secondary Dental Insurance:

Co. Name: _____

Address: _____

_____

Phone #: _____ Insured's ID #: _____

Group # (Plan, Local, or Policy #): _____

Insured's name: _____ Relation: _____

Date of Birth: _____ Insured's Employer: _____

Account Info

Person Ultimately responsible for Account:

Name: _____ Relation: _____

Billing Address: _____

SIN #: _____ Work #: _____

Dental Information

Reason for Today's visit: Exam_____Emergency_____Consultation_____
Are you in pain: No____Yes____How long?_____
Please indicate any of the following:

_____Discomfort, clicking or popping in jaw	_____Lost broken fillings	_____stained teeth
_____Red, swollen or bleeding gums	_____Teeth grinding	_____locking jaw
_____Sensitive tooth, teeth or gums	_____Ringing in ears	_____Bad breath
_____Blisters/sores in or around the mouth	_____Broken chipped tooth	

Others:_____
Do you require Premedication: _____Yes _____No _____Don't know
Previous Dentist:_____Dental Exam:_____
Last Dental Xrays:_____
Times a Day you brush:_____Times a week you floss:_____

What medications are you taking:_____
Do you have or have you had any of the following diseases, medical conditions or procedures?

__Y__N Heart Attack/ Stroke	__Y__N Thyroid Problems	__Y__N Cancer/Tumors
__Y__N Heart Surg./ Pacemaker	__Y__N Kidney Problems	__Y__N Shingles
__Y__N Heart Murmur	__Y__N Liver Problems	__Y__N Hepatitis
__Y__N Rheumatic Fever	__Y__N Respiratory Problems	__Y__N HIV + / AIDS / ARC
__Y__N Mitral Valve Prolapsed	__Y__N Sinus Problems	__Y__N Arthritis/ Rheumatism
__Y__N Artificial Valves	__Y__N Stomach Problems/Ulcers	__Y__N Artificial Bone Joints
__Y__N Heart Diseases	__Y__N Psychiatric Problems	__Y__N Emphysema
__Y__N Congenital Heart Defect	__Y__N Venereal Disease	__Y__N Fainting/ Epilepsy
__Y__N Chest Pains	__Y__N Alcohol/ Drug Abuse	__Y__N Frequent Headache
__Y__N Nervousness	__Y__N Tuberculosis/ TB	__Y__N Neck Pain
__Y__N Jaw Problems	__Y__N Cosmetic Surgery	__Y__N Chemotherapy
__Y__N Asthma	__Y__N Difficulty in Breathing	__Y__N Diabetes/Hypoglycem
__Y__N Leukemia	__Y__N Anemia	__Y__N High/Low Blood Pres
__Y__N Bleeding Problems	__Y__N Glaucoma	

Are you Allergic to any of the following? _____Latex_____Penicillin/Amoxicillin_____Tetracycline
____Aspirin____Dental Anesthetic_____Foods_____
Do you smoke? ____Yes ____No How much?_____How long?_____

For Women:
Are you taking Birth Control Pills? ____Yes____No
Are you pregnant? ____Yes_____No How long?_____Are you nursing?____Yes____No

Signature:_____Date:_____