Patient Information

Date ________________

Patient's Name ____ ______________ ____
Last First Middle Marital Status Sex

Address____
Street City State Zip

How long at this address________________________ Home Phone_____________________________

Hobbies_____________________________________ Email ___________________________________

Cell Phone________________Birthdate________________Social Security #_____________________

Employer__________________ Occupation_________________ Work Phone _______________

Spouse's Name____
Last First Middle

Employer_________________________Occupation_________________ Work Phone ___________

Social Security #_____________________Birthdate______________Cell Phone__________________

Whom may we thank for referring you to our office?____

Dental Insurance Information

Insured's Name_________________________________Social Sec.#____________________________

Insurance Company_____________________Group No.____________Subscriber ID-_____________

Insurance Co. Address____

Ins. Primary Phone No._____________________Ins. Secondary Phone No.______________________

Do you have dual coverage? Yes No If yes:

Insured's Name___________________________________Social Sec. #_________________________

Insurance Company______________________________Group No._________Local No.______________

Insurance Co. Address____

Insured's Employer____

Emergency Information

Name of nearest relative not living with you____
Complete Address____
Phone_______________________

Release: I authorize release of any information concerning my dental care, advice and treatment to the general dentist and/or dental specialist of record.

Acknowledgement of receipt of notice of privacy practices – By signing I have reviewed this office's Notice of Privacy Practices.

PATIENTS SIGNATURE____

Updates (date & initial) __________ __________ __________ __________ __________ __________

Patient's
Dentist____
____

Last Exam (or Check up) _________________________ Last Cleaning Date
____

List any medications or supplements you are currently
taking____

____
____

Medical History

Are you in good health? Yes No

Any history of major illness? Yes No

Please
list____
____

CHECK ANY OF THE FOLLOWING FOR WHICH PATIENT HAS BEEN TREATED OR DIAGNOSED

____Diabetes ____Asthma ____Sexually Transmitted Disease

____Pneumonia ____Kidney Involvement ____Valve or Joint Replace/Repair

____Rheumatic Fever ____HIV or AIDS ____Fainting or Dizziness

____Autoimmune Disorders ____Prolonged Bleeding ____Tuberculosis

____Cancer ____Nervous Disorders ____Arthritis

____Anemia ____Hepatitis ____High Blood Pressure

____Epilepsy ____Bone Disorders ____Heart Murmur

Other Serious
Illnesses____
______

Do you have a tendency to colds? Yes No Sore throats? Yes No Ear infections? Yes No

Have your tonsils been removed? Yes No Adenoids Removed? Yes No What age?_____

Do you use tobacco products? Yes No

List any allergies or drug
sensitivity____

Dental History

Have there been any injuries to the face, mouth, or teeth? Yes No
Do you have any speech problems? Yes No
Are you a mouth breather while awake or asleep? Yes No

Have you been informed of any missing or extra permanent teeth?   Yes   No
Do you have any habits affecting the teeth? (e.g. grinding, clenching)   Yes   No
Have you previously consulted an orthodontist?   Yes   No
Reason for consultation, (main concerns):

____
____

____
____

____
Patient Signature