



Patient Information Last Name: _____ First: _____ Middle Initial: _____ Sex: M F
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ Pager: _____ Cell Phone: _____
 E-Mail Address: _____ Date of Birth: _____ Marital Status: S M W D Child
 Employer: _____ SS#: _____ Driver's License #: _____

Responsible Party Information Last Name: _____ First: _____ Middle Initial: _____ Sex: M F
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ Pager: _____ Cell Phone: _____
 E-Mail Address: _____ Date of Birth: _____ Marital Status: S M W D
 Employer: _____ SS#: _____ Driver's License #: _____

Dental Insurance Information Subscriber: _____ SS #: _____ Date of Birth: _____ Group #: _____
 Employer: _____ Insurance Company: _____ Insurance#: _____
 Insurance Address: _____

Payment Method: Cash Check American Express Discover Master Card Visa

Referral Method Yellow Pages Newspaper TV Radio Sign Insurance Family Internet Magazine
 Zephyr's Game Church Bulletin City Buses Friend: _____ Other: _____

MEDICAL HISTORY

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

Blood Thinners	Yes No	Heart Disease	Yes No	Chest Pain	Yes No	Stroke	Yes No
Heart Attack	Yes No	Cardiac Pacemaker	Yes No	Diabetes	Yes No	Asthma	Yes No
Rheumatic Fever	Yes No	Heart Murmur	Yes No	Epilepsy	Yes No	Leukemia	Yes No
Swollen Ankles	Yes No	Fainting/Seizures	Yes No	AIDS/HIV	Yes No	Anemia	Yes No
High/Low Blood Pressure	Yes No	Thyroid Problems	Yes No	Angina	Yes No	Cancer	Yes No
Frequently Tired	Yes No	Emphysema	Yes No	Arthritis	Yes No	Hepatitis	Yes No
Weight Loss	Yes No	Hay Fever/Allergies	Yes No	Glaucoma	Yes No	Tuberculosis	Yes No
Radiation Treatment	Yes No	Mitral Valve Prolapse	Yes No	Joint Replacement	Yes No	Liver Disease	Yes No

List any medications you are currently taking. _____
 Have you ever had an allergic reaction to: Local Anesthetics Sedatives Penicillin Codeine Aspirin Sulfa Drugs Other _____
 Do you have a medical condition the Doctor should be aware of? Yes NO _____

PATIENT DENTAL HISTORY

1. Do your gums bleed while brushing or flossing?	Yes No	8. Do you have frequent headaches?	Yes No
2. Are your teeth sensitive to hot or cold?	Yes No	9. Do you clench or grind your teeth?	Yes No
3. Do you feel pain to any of your teeth?	Yes No	10. Do you bite your lips or cheeks?	Yes No
4. Are your teeth sensitive to sweets?	Yes No	11. Are you wearing dentures or partials over 5 yrs old?	Yes No
5. Do you have any sores or lumps in your mouth?	Yes No	12. Would you like a whiter & brighter smile?	Yes No
6. Have you had any head, neck or jaw injuries?	Yes No	13. Are you unhappy with the appearance of your teeth?	Yes No
7. Have you ever experienced any of the following: problems in your jaw?		14. Are you missing any teeth not replaced by a bridge or denture?	Yes No
a) Clicking?	Yes No	15. Do you use tobacco products	Yes No
b) Pain (joint, ear, side of face)	Yes No		
c) Difficulty in opening or closing?	Yes No		
d) Difficulty in chewing?	Yes No		

Signature I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

 Patient or Guardian

 Date