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Patient Personal Information

Title: _____ Nickname: _____ Birth Date _____ Age _____
Last, First: _____ Marital Status _____ Gender _____
Address: _____ Home # _____ Work # _____
_____ Cell # _____ Drive Lic # _____
City, State, Zip _____ Family Physician _____ Physician _____
Email _____ Last physical, date ___/___/___ Phone # _____
Health Care Guardian Name _____ School Name _____
Health Care Guardian Phone # _____ Referring Dentist _____ SSN _____

Person responsible/guarantor for paying bills

Guarantor, title: _____ Nickname: _____ Birth Date _____ Age _____
Last, First: _____ Marital Status _____ Sex _____
Address: _____ Home # _____ Work # _____
_____ Cell # _____ Drive Lic # _____
City, State, Zip _____ SSN _____
Email _____

Do you have Primary Dental Insurance? ___Yes ___No Do you have Secondary Dental Insurance? ___Yes ___No

Group No/Name		Group No/Name	
Insurance Name		Insurance Name	
Phone #		Phone #	
Employer Name		Employer Name	
Subscriber Last, First		Subscriber Last, First	
Subscriber Address		Subscriber Address	
City, State, Zip		City, State, Zip	
Relationship to Patient	Birth Date	Relationship to Patient	Birth Date
Subscriber ID/SSN		Subscriber ID	

Patient Medical Information — Check, if applicable

☐ No Changes

Allergic To

☐ No Known Allergies
☐Y ☐N Aspirin
☐Y ☐N Barbiturates/Sleeping Pills
☐Y ☐N Codeine
☐Y ☐N Erythromycin
☐Y ☐N Iodine
☐Y ☐N Latex Rubber
☐Y ☐N Local Anesthetics
☐Y ☐N Metals
☐Y ☐N Epinephrine
☐Y ☐N Penicillin
☐Y ☐N Sulfa Drugs
☐Y ☐N Other Narcotics
☐Y ☐N Other

☐Y ☐N Arthritis
☐Y ☐N Asthma
☐Y ☐N Autoimmune Disease
☐Y ☐N Bladder Trouble
☐Y ☐N Blood Clotting Problems
☐Y ☐N Blood Transfusions
☐Y ☐N Bulimia
☐Y ☐N Bronchitis
☐Y ☐N Cancer/Tumor or Growth
☐Y ☐N Cardiovascular Disease
☐Y ☐N Chemotherapy
☐Y ☐N Chest Pain/Angina
☐Y ☐N Color Blindness
☐Y ☐N Diabetes
☐Y ☐N Congenital Heart Defect
☐Y ☐N Fainting/Dizzy Spells
☐Y ☐N Delay in healing

☐Y ☐N Fever Blisters
☐Y ☐N Frequent Headaches
☐Y ☐N Frequently Dry Mouth/ Sjogren
☐Y ☐N Gag Reflex
☐Y ☐N Gall Bladder Trouble
☐Y ☐N Heart Attack
☐Y ☐N Heart Disease
☐Y ☐N Heart Murmur
☐Y ☐N Heart Surgery
☐Y ☐N Hepatitis
☐Y ☐N Herpes
☐Y ☐N High Blood Pressure
☐Y ☐N Hives
☐Y ☐N Jaundice
☐Y ☐N Joint Replacement
☐Y ☐N Kidney/Dialysis
☐Y ☐N Irregular heart beat

☐Y ☐N Pacemaker
☐Y ☐N Persistent Diarrhea
☐Y ☐N Premedicate
☐Y ☐N Prosthetic Heart Valve
☐Y ☐N Radiation Treatment
☐Y ☐N Rheumatic Fever
☐Y ☐N Rheumatic Heart Disease
☐Y ☐N Rheumatoid Arthritis
☐Y ☐N Seizures
☐Y ☐N Sexually Transmitted Disease
☐Y ☐N Shortness of Breath
☐Y ☐N Skin Rash
☐Y ☐N Sinus Trouble
☐Y ☐N Stomach Ulcers
☐Y ☐N Stroke

☐Y ☐N Thyroid Problems	☐Y ☐N Contact Lenses	☐Y ☐N Liver Disease	**FOR OFFICE USE ONLY**
☐Y ☐N Abnormal Bleeding	☐Y ☐N Congestive Heart Failure	☐Y ☐N Low Blood Pressure	☐Y ☐N See Scanned
☐Y ☐N AIDS/HIV Infection	☐Y ☐N Damaged Heart Valve	☐Y ☐N Lupus	☐ ☐ Documents: Pt. Note
☐Y ☐N Alcohol/Drug Abuse	☐Y ☐N Diabetes	☐Y ☐N Mental Health Problems	Y N Needs Update
☐Y ☐N Anorexia	☐Y ☐N Emphysema	☐Y ☐N Mitral Valve Prolapse	☐Y ☐N Scanned/Updated
☐Y ☐N Anemia	☐Y ☐N Environmental Allergies	☐Y ☐N Tuberculosis	☐ ☐
☐Y ☐N Ankles/Joints Swell	☐Y ☐N Epilepsy	☐Y ☐N Unusual Weight Loss	
☐Y ☐N TMJ problems	☐Y ☐N Leukemia	☐Y ☐N Urinate Frequently	

Medications

Are you taking any medication or drugs? If yes, please list: _____

_____

_____

_____

Are you taking any bisphosphonates now or have you taken them in the past (Fosamax)? ☐Y ☐N

Dental Questionnaire

Additional Comments

Any Disease, Condition or Problem not Listed? Please list _____

_____

_____

Rate your discomfort on a scale of 1 to 10 (1 barely noticeable, 10 unbearable)? 1 2 3 4 5 6 7 8 9 10

Medical Questionnaire

Emergency contact name _____

Emergency contact phone _____

Emergency contact relationship to patient _____

Doctor Signature

Signed: _____ _____

Date: _____ _____

By signing below, I certify that all of the above information is true to the best of my knowledge

_____ _____

Patient/Guardian Signature **Date**