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 NHUV0LOO5G6(6WH
 WODWD
 SKRH
 ID

Patient Personal Information

Title:	Nickname:	Birth Date	Age
Last, First:		Marital Status	Sex
Address:		Home #	Work #
		Cell #	Drive Lic
City, State, Zip		Emergency Contact	Emergency Phone #
Email		Student	SSN
Health Care Guardian Name		School Name	
Health Care Guardian Phone #		Referral Type	

Person responsible/guarantor for paying bills

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	Insurance Name	Phone #	Employer Name	Subscriber Last, First	Subscriber Address	City, State, Zip	Relationship to Patient	Birth Date	Subscriber ID

Patient Medical Information Check, if applicable

<input type="checkbox"/> No Changes	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fever Blisters	<input type="checkbox"/> Pacemaker
Allergic To	<input type="checkbox"/> Asthma	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Persistent Diarrhea
<input type="checkbox"/> No Known Allergies	<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Frequently Dry Mouth/ Sjoren	<input type="checkbox"/> Premedicate
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Bladder Trouble	<input type="checkbox"/> Gag Reflex	<input type="checkbox"/> Prior Hepatitis
<input type="checkbox"/> Barbiturates/Sleeping Pills	<input type="checkbox"/> Blood Clotting Problems	<input type="checkbox"/> Gall Bladder Trouble	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Codeine	<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Rheumatic Heart Disease
<input type="checkbox"/> Iodine	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Latex Rubber	<input type="checkbox"/> Cancer/Tumor or Growth	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Seizures
<input type="checkbox"/> Local Anesthetics	<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Metals	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Herpes	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Chest Pain Upon Exertion	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Color Blindness	<input type="checkbox"/> Hives	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Other Narcotics	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Kidney	<input type="checkbox"/> Stroke
<input type="checkbox"/> Other			

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

Dental Questionnaire	
Additional Comments	
Any Disease, Condition or Problem not Listed? Please list	_____

Rate your smile on a scale of 1 to 10 (1 dislike, 10 like very much)?	
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