PATIENT INFORMATION

Today's Date: ____________

First Name: _________________ Middle Name: _____________ Last Name: __________________________

Name that you prefer to be called: ____________________________________

Sex: ☐M ☐F Date of Birth: ____________ Social Security Number: ___________________________

Address: ___________________________________ City ______________State _______ Zip ____________

Phone number: (h) __________________________ (c)_____________________ (w) ___________________

Email address: ____

Preferred method of communication: ☐ Phone call ☐ Text message ☐ Email

Marital status: ☐M ☐S ☐W ☐D **Number of children: _________ Children's ages _____________**

Are you presently employed? ☐Yes ☐No ☐Full time ☐Part time ☐Unemployed ☐Disabled ☐Retired

Occupation: __________________________ Employer: __________________________

What is the reason for seeing us today? ____

Who may we thank for referring you? ____

What can we do to ensure your experience with us is a pleasant one? ________________________________

What was the reason you stopped seeing your previous dentist? ____________________________________

SUBSCRIBER EMPLOYMENT INFORMATION

The following is for: ☐ patient ☐ the insurance policy holder

Employer Name:____ Phone:__________________________

Address: ___________________________________ City ______________State _______ Zip ____________

Occupation: ______________________________________

SPOUSE OR SUBSCRIBER EMPLOYMENT INFORMATION

The following is for: ☐ **patient's spouse** ☐ the insurance policy holder

First Name__________________ Middle Name______________ Last Name __________________________

Name that you prefer to be called: ____________________________________

Sex: ☐M ☐F Date of Birth: ____________ Social Security Number: ___________________________

Address: ___________________________________ City ______________State _______ Zip ____________

Phone number: (h) __________________________ (c)_____________________ (w) ___________________

Email address: ____

DOCTOR HISTORY

Primary Care or Referring Physician (Name & Phone): ____

Previous Dentist (Name & Phone): ____

EMERGENCY CONTACTS

Emergency Contact (Name & Phone): ____

Emergency Contact (Name & Phone): ____

INSURANCE INFORMATION

Primary Dental Insurance

Insurance Name: ____ Phone #: _________________________

Subscriber Name: _________________________________ Subscriber ID#: ________________________

Subscriber Social Security #:______________________________ Subscriber Date of Birth: _______________

Group / Policy Number: _______________________

Is this an employer or union policy? __________________

Secondary Dental Insurance

Insurance Company Name: __________________________________ Phone #__________________________

Subscriber Name: _________________________________ Subscriber Employer: ________________________

Subscriber Social Security #:______________________________ Subscriber Date of Birth: _______________

Group / Policy Number: _______________________________

Is this an employer or union policy? __________________

Primary Medical Insurance

Insurance Company Name: __________________________________ Phone #__________________________

Subscriber Name: _________________________________ Subscriber Employer: ________________________

Subscriber Social Security #:______________________________ Subscriber Date of Birth: _______________

Group / Policy Number: _______________________________

Do you have secondary medical insurance? __________________

MEDICAL HISTORY

Patient's Name: ____ **Today's Date:** ____________

Date of Last Physical: ______________________ Weight: _____________ Height: _______________

Please check if you have ever had any of the following:

- ☐ Allergies (seasonal)
- ☐ Allergies to latex
- ☐ Allergies to medications (list below)
- ☐ Acid Reflux/ GERD
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Angina / Chest pain
- ☐ Anxiety
- ☐ Blood disease
- ☐ Breast Implants
- ☐ Breathing problems
- ☐ Bleeding disorder
- ☐ Chronic bronchitis
- ☐ Chronic fatigue
- ☐ Cancer or tumors
- ☐ Circulation problems
- ☐ Congenital heart condition
- ☐ Diabetes
- ☐ Drug / Alcohol abuse
- ☐ Depression
- ☐ Dizziness
- ☐ Earaches
- ☐ Emphysema
- ☐ Epilepsy / seizures
- ☐ Eating disorder
- ☐ Fainting / dizzy spells
- ☐ Glaucoma
- ☐ Gall bladder problems
- ☐ Herpes
- ☐ Heart disease
- ☐ Heart Valve replacement
- ☐ Head / neck trauma
- ☐ Heart attack
- ☐ Healing problems
- ☐ Headaches
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV / AIDS
- ☐ Immune system disorder
- ☐ Infective endocarditis
- ☐ Jaundice
- ☐ Joint replacement
- ☐ Kidney disease
- ☐ Joint disease
- ☐ Liver disease
- ☐ Lupus
- ☐ Mitral valve prolapse
- ☐ Neurological problems
- ☐ Nervous disorders
- ☐ Neurological disorder
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Persistent cough
- ☐ Panic attacks
- ☐ Prosthetic joint
- ☐ Psychiatric care
- ☐ Psychological disorders
- ☐ Pacemaker
- ☐ Radiation therapy
- ☐ Ringing in ears (Tinnitus)
- ☐ Rheumatic fever
- ☐ Rheumatoid arthritis
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ STD
- ☐ Sleep apnea
- ☐ Stomach problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid disorder
- ☐ Ulcers
- ☐ Other ______________________

Do you have any allergies to medications?

☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Tetracycline ☐ Penicillin ☐ Sulfa

☐ Other allergies to medications (please list): ____

If you checked any of the above or have other medical conditions, please explain: ______________________

____

____

Number of alcoholic drinks per week: _______

Do you or have you ever smoked or used chewing tobacco? ☐ YES ☐NO

If yes, how much and for how long? ____

Have you had a **heart attack or heart surgery (bypass/stent)** in the last 6 months? **☐Yes ☐No** **Have you ever taken "bisphosphonates"** (Fosamax, Actonel, Aredia, or Pamidronate?) **☐Yes ☐No**

Do you need to be pre-medicated with antibiotics for dental treatment? ☐Yes ☐No

Women Only:

Any chance you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Please list ALL medications that you are currently taking:

☐ I take no medications at this time

Medication	How often	For What	Amount taken	Doctor

I certify that the above is true to the best of my knowledge. I understand that if there are any changes to my health or medications, I will advise my dentist before beginning any treatment.

Patient **Name: ________________________________ Today's Date: ______________**

Patient Signature: ____

DENTAL HISTORY

Patient's Name: ________________ Date: ____________ Date of last dental exam:______________

Date of last cleaning:____________ How often do you brush? ___________ How often do you floss? _______

Please check all that apply to you:

☐ Bleeding gums	☐ Tooth removal	☐ Food gets stuck	☐ Accident in past	☐ Pain when chewing
☐ Tooth decay	☐ Braces	☐ Loose teeth	☐ Gum surgery	☐ Jaw surgery
☐ Broken teeth	☐ Sensitive teeth	☐ Toothache	☐ Bad breath	☐ Hot / cold sensitive
☐ Wear of teeth	☐ Crowding of teeth	☐ Dry mouth	☐ Other: __________________________	

Are you happy with the way your teeth look?☐YES ☐NO If not, why? _________________________

Are you dissatisfied with any of the following?

☐ Shape of teeth	☐ Crowding	☐ Silver fillings	☐ Color	☐ Length
☐ Spacing	☐ Old fillings	☐ Misalignment	☐ **"Gummy" smile**	☐ Old crowns
☐ Bad bite	☐ Other			

Do you have any sores / spots in mouth that haven't healed for more than 2 weeks? ☐ Yes ☐ No

Please check all that apply to you:

☐ TMJ problems	☐ Jaw clicking	☐ Pain in jaw	☐ Grinding teeth
☐ Pain in facial area	☐ Numbness in fingers	☐ Tingling in fingers	☐ Dizziness (vertigo)
☐ Ringing in ears	☐ Numbness in face	☐ Neck or back pain	☐ Jaw clenching
☐ Tightness in face	☐ Wear a night guard	☐ History of jaw lock	☐ Difficulty chewing
☐ Difficulty opening mouth	☐ Pain behind eyes	☐ Trigeminal neuralgia	☐ Bells Palsy

Headache history: please check all that apply to you

Location of pain: ☐ Front of head / forehead ☐ Side of head ☐ Back of head

Intensity of pain: 0 (no pain) 1 2 3 4 5 6 7 8 9 10(extreme pain)

Do you suffer from morning headaches? ☐ Yes ☐ No ☐ Sometimes

Do headaches wake you up from sleep? ☐ Yes ☐ No ☐ Sometimes

Do you have nausea with headaches? ☐ Yes ☐ No ☐ Sometimes

Frequency of headaches: ☐ Constant ☐ Once/day ☐ Once every few days ☐ Once/week

Sleep Apnea Assessment: please check all that apply to you

Have you ever been diagnosed with Sleep Apnea? ☐ Yes ☐ No If yes, when? ___________

Diagnosing physician: _________________________ Name of sleep center? ________________________

Please check all that apply to you:

☐ Snoring	☐ Gastro-esophageal reflux	☐ Insomnia
☐ Gasping for air during sleep	☐ Feel tired in morning	☐ Poor concentration
☐ Poor memory	☐ Difficulty breathing through nose	☐ Fatigue
☐ Trouble sleeping	☐ Nervousness	☐ Excessive daytime sleepiness
☐ Irritability	☐ Anxiety / depression	☐ Morning stiffness

Have you ever used a CPAP device and could not tolerate it? ☐ Yes ☐ No

If you were not able to tolerate the CPAP, why? ___________________________________