A CARING PLACE DENTISTRY

PATIENT INFORMATION IF UNDER AGE 18 *Please Print*

LAST NAME	FIRST NAME	MIDDLE:
BIRTHDAY:	SSA:	SEX: M F

ADULT PATIENT OR RESPONSIBLE PARTY

LAST NAME	FIRST NAME	MIDDLE:
MAILING ADDRESS:	CITY:	STATE:
SOCIAL SECURITY # :	ZIP CODE:	
CELL #	HOME #	WORK #:
DATE OF BIRTH:	SEX: M F	**MARITAL STATUS: S M D W**
OCCUPATION:	EMPLOYER	

DENTAL INSURANCE

PRIMARY INSURANCE:	GROUP#:	SECONDARY INSURANCE:
INSURED'S NAME:		INSURED
SOCIAL SECURITY #:		SSA#
DATE OF BIRTH:		DATE OF BIRTH
EMPLOYER:		EMPLOYER:

DENTAL HISTORY

REASON FOR VISIT: EMAIL:

WHAT DENTAL PROBLEMS ARE YOU HAVING NOW?

HOW DID YOU SELECT OUR OFFICE?

LAST DENTAL EXAM: LAST CLEANING:

LAST FULL MOUTH X-RAYS (14 OR MORE):

HAVE YOU EVER HAD PERIODONTAL TREATMENT FOR GUM DISEASE?

PLEASE GIVE DETAILS: **DO YOU TAKE BLOOD THINNERS? YES NO**

DO YOU WEAR DENTURES OR PARTIALS? HAVE YOU HAD TMJ PROBLEMS? YES NO

IF PROBLEMS GIVE DETAILS:

ARE YOU INTERESTED IN COSMETIC DENTISTRY TO IMPROVE YOUR SMILE?

MEDICAL INFORMATION

Are you currently taking any medications?	Y N	**Physician Name:**	**Phone #:**
Do you smoke or use tobacco?	Y N	If Yes, Please List:	
Are you taking birth control pills?	Y N	**Pharmacy Phone # :**	
Are you pregnant? If yes # of weeks:		Are you nursing? YES NO	
		Have you taken phenfen for weight loss? Yes No	

Conditions *Please Circle Yes or No*

Abnormal Bleeding	Yes No	Glaucoma	Yes No	Stroke	Yes No		
Alcohol Abuse	Yes No	Hay Fever	Yes No	Thyroid Problems	Yes No		
Allergies	Yes No	Heart Attack	Yes No	Tuberculosis	Yes No		
Anemia	Yes No	Heart Surgery	Yes No	Ulcers	Yes No		
Angina Pectoris	Yes No	Hemophilia	Yes No	Venereal Disease	Yes No		
Arthritis	Yes No	Hepatitis A	Yes No	Yellow Jaundice	Yes No		
Artificial Joints	Yes No	Hepatitis B	Yes No	**Allergies**			
Artificial Heart Valve	Yes No	High Blood Pressure	Yes No	Amoxicillin	Yes No		
Asthma	Yes No	HIV+AIDS	Yes No	Aspirin	Yes No		
Blood Transfusion	Yes No	Kidney Problems	Yes No	Codeine	Yes No		
Cancer-Chemotherapy	Yes No	Liver Disease	Yes No	Dental Anesthetics	Yes No		
Colitis	Yes No	Low Blood Pressure	Yes No	Erythromycin	Yes No		
Congenital Heart Defect	Yes No	**Mitro Valve Prolapse**	Yes No	Jewelry	Yes No		
Cosmetic Surgery	Yes No	Pace Maker	Yes No	**Latex**	Yes No		
Diabetes	Yes No	Pneumocystitis	Yes No	Metals	Yes No		
Difficulty Breathing	Yes No	Psychiatric Problems	Yes No	Penicillin	Yes No		
Drug Abuse	Yes No	Radiation Therapy	Yes No	Tetracycline	Yes No		
Emphysema	Yes No	Rheumatic Fever	Yes No	**List other allergies:**			
Epilepsy	Yes No	Seizures	Yes No				
Fainting Spells	Yes No	Shingles	Yes No	**Pre-Medication Required: Yes No**			
Fever Blisters	Yes No	Sickle Cell disease	Yes No	**If Yes please state why:**			
Frequent Headaches	Yes No	Sinus Problems	Yes No				

PATIENT SIGNATURE: **DATE:**

OR PARENT IF UNDER 18 YRS **DOCTOR SIGNATURE:** **DATE:**