



PATIENT INFORMATION

Date

Patient Name (Last, First, Middle)

Birth Date

Gender: Male Female

School (if applicable)

Nickname

Hobbies

Address

City/Zip

Home #

Cell #

Whom may we thank for referring you to our office?

Any family members treated in our office?

Responsible Party Email

RESPONSIBLE PARTY INFORMATION

Name

Marital Status

Residence Address

City/Zip

Mailing Address

City/Zip

Home #

| Work #

| Cell #

Employer

Occupation

Social Security #

Birth Date

Relationship to patient



Spouse's Name

Relationship to Patient

Employer

Occupation

Social Security #

Birth Date

Work #

FAMILY INFORMATION (If Patient is a Minor)

With whom does the patient live (custodial parent)?

Are the patient's parents separated?

Divorced?

Remarried?

Patient's Siblings (Names & Birth Dates)

INSURANCE INFORMATION

If you have HMO coverage, do you need a referral approved before starting?

Subscriber's Name

Birth Date

Subscriber's SSN or ID #

Insurance Company Name

Phone #

Insurance Company Address

Do you have dual coverage?



MEDICAL HISTORY

Patient Name

Physician Name
Patient's Height

Date Last Seen
Weight

Has the patient been under the care of a physician during the last two years?
If yes, for what conditions?

Does the patient have a current medical problem?

Is the patient currently taking or using any pills, medications, or drugs? If yes, please list.

Has the patient had an unusual reaction to any medication?

Has the patient ever had an injury to the head, face or mouth?

Has the patient ever had a serious illness?

Has the patient ever had surgery or been hospitalized?

Has the patient ever had the tonsils or adenoids removed? Age

Is the patient or could the patient possibly be pregnant?

Do you anticipate the patient needing a MRI in the near future? When?

Does the patient have any congenital (born with) problems?

Has the patient ever been diagnosed with a heart murmur?

Has a doctor/dentist recommended that the patient take antibiotics prior to dental work?

Is the patient allergic to anything (foods, medications, etc.)? If yes, please list.

Has the patient ever been diagnosed or treated for any of the following:

Diabetes	Bone disease	Tuberculosis	Bleeding disorder
Fainting/Dizziness	Endocrine problem	Ulcers	Recurrent pain
Arthritis	Epilepsy	Cancer	Multiple sclerosis
Anemia	Hepatitis	Joint replacement	Nervous disorder
Heart condition	Pneumonia	Emotional problem	Growth disorder
Kidney problem	AIDS or HIV	Learning disability	Allergies
Liver problem	Asthma	Prolonged bleeding	Low/High blood pressure
Breathing trouble	Rheumatic fever	Cerebral Palsy	Communication disability



DENTAL HISTORY

Patient's Dentist

Date of Last Cleaning

- Is the patient currently undergoing any dental treatment?
- Does the patient ever have temperature sensitive teeth or bleeding gums?
- Has the patient had any teeth extracted? Why?
- Has the patient ever injured or broken any teeth?
- Does the patient have any missing or extra teeth?
- Does the patient have any difficulty eating, speaking or swallowing?
- Does the patient have any habits such as thumb sucking or nail biting?
- Does the patient have any dental or facial pain?
- Does the patient's jaw joints make noise or hurt?
- Has the patient's jaw ever locked open or closed?
- Does the patient habitually grind or clench the teeth together?
- Does the patient normally breathe with the lips apart and through their mouth?
- Is the patient aware of any swelling or growths in the mouth or face?
- Is there any other medical or dental information we should know?

Signature (Parent or guardian if patient is a minor) _____

Date