Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name: ________________________________ M.I.: _____ Last Name: _____________________________________

Sex: ☐ Male ☐ Female ☐ Additional Category (please specify): ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed/Widower ☐ Separated

Date of Birth: ____ Age: ____

Social Security #: ______________________________________ Driver's License #: ________________________________

Street Address: _____________________________ Apt: ____ City: _________________ State: _____ Zip: ___________

Home Phone: ______________________ Cellphone: ______________________ Work Phone: ______________________

Email Address: ____

Job Title: _______________________________________ Employer Name: _______________________________________

Emergency Contact Name: ____________________________ Tel.: ___________________ Relation: ____________________

Are you a new patient of our practice? ☐ Yes ☐ No

Is a family member a patient of our practice? ☐ Yes ☐ No

Referred By: ____

Account Information

Who will be responsible for your account? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other: __________________

(If you selected "Self" above, please skip this section)

First Name: ________________________________ M.I.: _____ Last Name: _____________________________________

Date of Birth: ____ Age: ____

Social Security #: ______________________________________ Driver's License #: ________________________________

Street Address: _____________________________ Apt: ____ City: _________________ State: _____ Zip: ___________

Home Phone: ______________________ Cellphone: ______________________ Work Phone: ______________________

Employer Name: ____

Insurance Information

Student: ☐ Full-Time ☐ Part-Time School Name: ___________________________ City: _____________ State: _____

Employed: ☐ Full-Time ☐ Part-Time ☐ Retired Do you belong to a PPO or HMO?: ☐ Yes ☐ No

Primary Insurance Information

Insurance Type: ☐ Dental ☐ Medical

Employer Name: ____

Employer Address: ___________________________________ City: _________________ State: _____ Zip: ___________

Employer Phone: ______________________________________

Insurance Company Name: _______________________________________ I.D. #: __________________________________

Group Name: _______________________________________ Group #: ____

Street Address: __________________________________ City: _____________________ State: _____ Zip: ___________

Tel.: ____

Subscriber's Name: ______________________________________ Subscriber's DOB: ________________________________

Subscriber's SSN: ________________________________ Relation to Subscriber: ___________________________________

Dental Health Specialists

Secondary Insurance Information

Insurance Type: ☐ Dental ☐ Medical
Employer Name: ____________________
Employer Address: ____________________ City: ____________ State: _____ Zip: __________
Employer Phone: ____________________
Insurance Company Name: ____________________ I.D. #: ____________________
Group Name: ____________________ Group #: ____________________
Street Address: ____________________ City: ____________ State: _____ Zip: __________
Tel.: ____________________
Subscriber's Name: ____________________ Subscriber's DOB: ____________________
Subscriber's SSN: ____________________ Relation to Subscriber: ____________________

Dental Information

Reason for visit: ____________________
Are you in pain? ☐ Yes ☐ No If yes, for how long?: ____________________
Please indicate which of the following problems you have experienced:

☐ Discomfort, clicking, or popping in jaw	☐ Lost/broken filling(s)	☐ Stained teeth	☐ Difficulty closing jaw
☐ Red, swollen, or bleeding gums	☐ Teeth grinding/clenching	☐ Locking jaw	☐ Difficult opening jaw
☐ A removable dental appliance	☐ Ringing in ears	☐ Bad breath	☐ Loose/shifting teeth
☐ Blisters/sores in/around the mouth	☐ Broken/chipped tooth	☐ Burning tongue/lips	☐ Gum disease
☐ Food caught between teeth	☐ Prolonged bleeding from an injury/extraction	☐ Recent infections or sore throat	

☐ Other: ____________________
____

☐ Tooth sensitivity to: ☐ Hot ☐ Cold ☐ Sweets ☐ Biting
Date of Last Dental Visit: ____________________ Date of Last Dental X-Rays: ____________________
Name of General Dentist: ____________________
Street Address: ____________________ City: ____________ State: _____ Zip: __________
How many times a day do you brush?: ____________ How many times a week do you floss?: ____________
What type of toothbrush bristles do you use?: ☐ Soft ☐ Medium ☐ Hard

Medical Information

Have you been under the care of a medical doctor during the past two years?: ☐ Yes ☐ No
If yes, for what?: ____
Physician Name: ____
Pharmacy Name: _________________________________ Pharmacy Address: _______________________________________
Pharmacy Tel.: ___________________________________
Has a physician/previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No
Have you had any operation, or been hospitalized in the past five years?: ☐ Yes ☐ No
If yes, for what?: ____
Have you ever had general anesthesia?: ☐ Yes ☐ No
Have you or a family member ever had any unusual or serious reactions to general anesthesia?: ☐ Yes ☐ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?:

☐ Rheumatic fever	☐ Mental health problems	☐ Bleeding tendency	☐ Sexually transmitted diseases
☐ High blood pressure	☐ Problems with immune system	☐ Blood transfusion	☐ Contagious diseases
☐ Low blood pressure	☐ Delay in healing	☐ Blood disorder	☐ Infectious mononucleosis
☐ Mitral valve prolapse	☐ Hay fever / Sinus problems	☐ Bruise easily	☐ Swollen ankles
☐ Heart murmur	☐ Snoring	☐ Eye disease / Glaucoma	☐ Arthritis / Joint disease
☐ Chest pain / Angina	☐ Sleep Apnea / CPAP	☐ Jaundice / Liver disease	☐ Prosthetic implant
☐ Heart attack(s)	☐ Respiratory problems	☐ Hepatitis	☐ Joint replacement
☐ Irregular heartbeat	☐ Tuberculosis	☐ Gallbladder trouble	☐ Osteoporosis / Osteopenia
☐ Cardiac pacemaker	☐ Emphysema	☐ Fainting spells	☐ Osteonecrosis
☐ Heart surgery	☐ Smoke *# of packs a day:* _______	☐ Convulsions / Epilepsy	☐ Stomach ulcers
☐ Damaged heart valves	☐ Use chewing tobacco	☐ Stroke	☐ Tumor or growth
☐ Pneumonia / Bronchitis / Chronic cough	☐ History of drug abuse	☐ Thyroid trouble	☐ Cancer / Radiation / Chemotherapy
☐ Chronic fatigue / Night sweat	☐ History of alcohol abuse	☐ Diabetes	☐ On a diet
☐ Trouble climbing 1-2 flights of stairs	☐ Abnormal bleeding	☐ Low blood sugar	☐ Wear Contact lenses
☐ Anemia	☐ Asthma	☐ On dialysis	☐ Kidney trouble

Medication & Allergies			
Are you currently taking:			
☐ Nerve pills	☐ Pain killers (including aspirin)	☐ Muscle relaxers	☐ Stimulants
☐ Diet pills	☐ Tranquilizers	☐ Insulin	☐ Antidepressants
☐ Sleeping pills	☐ Blood thinners (Coumadin, Aspirin)	☐ Bone density meds or bisphosphonates such as Fosamax, Boniva, Actonel, IV Zometa, Reclast, Xgeva, Prolia, or Aredia within the last 12 years	

Please list any other medication(s) you are taking (including natural, herbal, homeopathic, or OTC products):

MEDICATION	DOSAGE	FREQUENCY

Are you allergic to, or had a reaction to:

☐ Penicillin	☐ Sulfa drugs	☐ Local anesthetic	☐ Amoxicillin
☐ Sodium pentothal/Valium/other tranquilizers	☐ Aspirin	☐ Codeine or other narcotics	☐ Latex
☐ Soy	☐ Eggs/yolk	☐ Sulfites	☐ Other

Please list any other medication or antibiotics you are allergic to:

____

____

Please list any allergies other than drug allergies:

____

____

1-4 below for women only *(antibiotics such as penicillin may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control)*

1. Is there a possibility of pregnancy? ☐ Yes ☐ No
2. Expected delivery date: ____
3. Are you nursing? ☐ Yes ☐ No
4. Are you taking birth control pills? ☐ Yes ☐ No

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by my Provider to help determine the appropriate dental treatment. If there are any changes in my medical status, I will inform the office.

Signature: ____ **Date:** ____________________________________