Patient Information (Confidential)

Name: _____Date:_____
Address:_____State/Zip Code:_____
Cell Phone:_____Home Phone:_____
Email address:_____
SS#/SIN:_____-_____-_____ Birth Date:_____

Check Appropriate Box:

- ❑ **Minor**
- ❑ **Single**
- ❑ **Married**
- ❑ **Divorced**
- ❑ **Widowed**
- ❑ **Separated**

Patient's or Parent's/Guardian's Employer:_____
Business Address:_____
Spouse or Parent's/Guardian's Name:_____

Whom may we thank for referring you? ✓ check the box : ( ) Google , ( )Facebook, ( ) Flyer, ( ) Friend, ( ) Referring Doctor, ( ) Road Sign

Emergency Contact Name: _____Phone:_____
***Primary Insurance Name:_____**
Subscriber's date of birth:_____
Subscriber's Social:_____
***Secondary Insurance Name:_____**
Subscriber's date of birth:_____
Subscriber's Social:_____

Patient's Health History:
Reason for visit:_____
Date of last dental visit:_____ Date of last x rays:_____
Are you in good health:_____

Preferred Pharmacy
Name:_____ Phone Number:_____
Street:_____ Zip:_____ City:_____ State:_____

Allergies:

- ❑ **Local Anesthetics Like Novocaine**
- ❑ **Penicillin or other Antibiotics**
- ❑ **Sulfa Drugs**
- ❑ **Barbiturates,Sedatives or Sleeping Pills**
- ❑ **Aspirin**
- ❑ **Iodine**
- ❑ **Any Metals**
- ❑ **Latex/Rubber**
- ❑ **Other(please list)_____**

Are you Pregnant or think you may be pregnant? _____
Are you nursing?_____ Are you taking birth control pills?_____

Oral Health
Have you ever been treated for periodontal (gum) disease? _____
Have you ever had Novocaine or other local anesthetic? _____
How happy are you with your smile (1-10)? _____
Are you currently wearing dentures? _____
Age of dentures? _____

Please check any conditions that apply to you below:

- ❑ **Teeth grinding/clenching**
- ❑ **Mouth sores**
- ❑ **Difficulty chewing/swallowing**
- ❑ **Pain in jaw (TMJ)**
- ❑ **Swollen or bleeding gums**
- ❑ **Broken or loose teeth**
- ❑ **Sensitive teeth**
- ❑ **Use tobacco products**

Health History

Please ✓ if you have any of the following:

- ❑ **Alcoholism**
- ❑ **Drug Addiction**
- ❑ **Rheumatic Heart Disease or Rheumatic Fever**
- ❑ **Scarlet Fever**
- ❑ **Heart Trouble,Heart Attack, Or Angina**
- ❑ **Chest Pain**
- ❑ **Shortness of Breath**
- ❑ **Pacemaker**
- ❑ **Heart Surgery**
- ❑ **High/Low Blood Pressure**
- ❑ **Congenital Heart Problem**
- ❑ **Swelling of feet,ankles, hands**
- ❑ **Hepatitis, Jaundice or Liver Disease**
- ❑ **Stroke**
- ❑ **Sinus Trouble**
- ❑ **Lung or Breathing Problems**
- ❑ **Asthma or Hay Fever**
- ❑ **Hives/Skin Rash**
- ❑ **Fainting or Dizzy Spells**
- ❑ **Diabetes**
- ❑ **AIDS or HIV Infection**
- ❑ **Thyroid Problems**
- ❑ **Allergies**
- ❑ **Arthritis**
- ❑ **Joint Replacement**
- ❑ **Stomach Ulcers**
- ❑ **Kidney Trouble**
- ❑ **Tuberculosis**
- ❑ **Persistent Cough**
- ❑ **Cough that produces blood**
- ❑ **Chemotherapy (Cancer,Leukemia)**
- ❑ **Sexually Transmitted Disease**
- ❑ **Epilepsy or Seizures**
- ❑ **Anemia**
- ❑ **Glaucoma**
- ❑ **Nervousness**
- ❑ **Tonsillitis**
- ❑ **Tumors**
- ❑ **Mental Health Care**
- ❑ **Back Problems**
- ❑ **Chemical Dependency**
- ❑ **Mitral Valve Prolapse**
- ❑ **Cortisone Treatment**
- ❑ **Cold Sores/Fever Blisters**
- ❑ **Hypoglycemia**
- ❑ **Eating Disorder**
- ❑ **Blood Thinners**
- ❑ **Other Not Listed Above:_____.**

List any medications you are taking including non-prescription drugs:

_____

_____

_____

_____

_____

_____