We appreciate the opportunity to care for your dental needs! Please tell us about yourself!

First Name & Middle Initial	Last Name	Social Security #
Address and Apartment #	City	Zip Code
Home Phone #	Cell Phone #	Date of Birth
Email	☐ Single ☐ Married ☐ Divorced ☐ Widowed	Sex ☐ Male ☐ Female

Who can we thank for referring you? (Patient, Insurance Website, Google)

____

Primary Insurance

Name and Date of Birth of Policyholder	Employer	Social Security # of Policyholder
Plan #	Group #	Phone # on Insurance Card
Member ID	Insurance Company	Relationship to Patient

Secondary Insurance

Name and Date of Birth of Policyholder	Employer	Social Security # of Policyholder
Plan #	Group #	Phone # on Insurance Card
Member ID	Insurance Company	Relationship to Patient

Primary Care Physician

Name of Doctor	City of Practice	Phone #
Are you being treated by your doctor for any illness? (Diabetes, Cancer, Asthma)		

Dental Health History

Times a day I brush: ______	Bleed when you floss ☐ Yes ☐ No	Difficulty Chewing ☐ Yes ☐ No	Had prolonged bleeding ☐ Yes ☐ No	Sores/Lumps in Mouth ☐ Yes ☐ No
Times a day I floss: ______	I use bristles that are ☐ Hard ☐ Medium ☐ Soft	Clench/Grind Teeth ☐ Yes ☐ No	Problems with dental work ☐ Yes ☐ No	Head/Neck/Jaw Injuries ☐ Yes ☐ No
Bite Lips/Cheeks ☐ Yes ☐ No	Sweet/Sour Sensitivity ☐ Yes ☐ No	Hot/Cold Sensitivity ☐ Yes ☐ No	Difficulty Opening/Closing ☐ Yes ☐ No	Discomfort in TMJ ☐ Yes ☐ No
Use tobacco? ☐ Yes ☐ No	Use alcohol? ☐ Yes ☐ No	Use drugs not prescribed by your own doctor? ☐ Yes, ______________ ☐ No		Abuse drugs or alcohol? ☐ Yes ☐ No

Do you have any respiratory problems? (Asthma, Emphysema, COPD)	Allergies? (Seasonal, food) ☐ Yes, ________________ ☐ No
Do you have any psychiatric problems or illnesses? (Anxiety, Depression)	Ever been recommended to take pre-appointment meds? ☐ Yes ☐ No

Women: Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No On birth control pill? ☐ Yes ☐ No

Do you have an allergy or hypersensitivity to any of the following:

Latex ☐ Yes ☐ No	Antibiotics (Penicillin, Amoxicillin, Tetracycline)	Other: (Medications)
Pain medication (Aspirin, Codeine, Local Anesthetics)		

Have you ever had surgery of any kind? (Brain, heart, donated/received an organ, joint replacement, ACL, etc.)

____

Do you take any medications? If many, please speak with an Administration Team Member for a comprehensive list.

____

Medical History - Please indicate if you have, or have had, any of the following:

Congenital Heart Defect ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Heart Attack ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Artificial Valves ☐ Yes ☐ No	Joint Replaced ☐ Yes ☐ No
Blood Pressure Issues ☐ Yes ☐ No	Cancer ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Abnormal Bleeding ☐ Yes ☐ No	Stomach Issues ☐ Yes ☐ No	Liver Problems ☐ Yes ☐ No
Cardiac Pacemaker ☐ Yes ☐ No	Autism ☐ Yes ☐ No	Pins or Plates ☐ Yes ☐ No	Blood Transfusion ☐ Yes ☐ No	Stents or Shunts ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Sexually Trans. Disease ☐ Yes ☐ No	HIV/AIDS ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No	Thyroid Problems ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No
Hepatitis Type_____ ☐ Yes ☐ No	Seizures ☐ Yes ☐ No	Fainting Spells ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Sinus Problems ☐ Yes ☐ No	Arthritis ☐ Yes ☐ No

Take a blood thinner? ☐ Yes ☐ No	Take a bisphosphonate? ☐ Yes ☐ No	Have an autoimmune disease? ☐ Yes, ______________________ ☐ No	Have Ulcerative Colitis? ☐ Yes ☐ No

Emergency Contact

Name:	Relationship to You:	Phone #:

Medical History Affirmation

I certify that I have read the above information and understand the questions. I affirm that I have answered the questions accurately and that providing incorrect information, knowingly or accidentally, may be dangerous to my health.

Signed ____ *Date* ________________

Medical History Affirmations For Upcoming Years

Signed ____ *Date* ________________

Signed ____ *Date* ________________

Signed ____ *Date* ________________