

A B C

PATIENT INFORMATION

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____ Marital Status _____

Social Security # _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's name _____ Relationship to patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____ Cell Phone _____

DENTAL INSURANCE INFORMATION

Insured's name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Phone No. _____

Insurance Co. Address _____

Insured's Employer _____ Insured's Birthdate _____

Do you have dual coverage? Yes q No q If yes:

Insured's name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Phone No. _____

Insurance Co. address _____

Insured's Employer _____ Insured's Birthdate _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____

Phone _____

Signature (Parent's signature if minor) _____

HEALTH HISTORY

Medical History

Please check if patient has, or has had...

- Joint swelling or Arthritis
- Bone disorders
- Heart trouble
- Diabetes
- Rheumatic Fever
- Hepatitis or Liver problems
- Emotional problems
- Tuberculosis
- AIDS or HIV
- Epilepsy
- Prolonged bleeding
- Endocrine problems
- Tonsils removed? If yes, when? _____
- Asthma, if so, what medication(s) _____
- Adenoids removed? If yes, when? _____

List any Allergies: _____

Dental History

Please check if patient has, or has had...

- Any injuries to face, mouth, teeth? (Circle)
- Thumb, finger or lip sucking habit(s)? Continuing Discontinued
- Mouth breathing when asleep, awake? (Circle)
- Any known missing permanent teeth?
- Any known extra permanent teeth?
- Any teeth removed by extraction? When?
- Is there a tongue thrust problem?
- Any clenching or grinding of teeth? Day Night Both
- Any pain, popping or locking on opening or closing jaw movement? (Circle)
- Frequent headaches? If yes, headaches per week AM PM
- Any muscle tenderness or stiffness in the jaw or neck? (Circle)
- Any ringing sounds in the ear, or spells or dizziness? (Circle)

PLEASE LIST YOUR CHIEF CONCERN(S) AND WHAT YOU WOULD LIKE TREATMENT TO ACCOMPLISH: _____

General Dentist: _____ **Phone #:** _____

Address: _____

ADDITIONAL CHILDREN IN FAMILY

NAMES:

AGE:

DATE OF BIRTH:

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