## Patient Information

Patient Name ___________________________________ Preferred Name/Nickname _________________________

Address ____________________________________________________________________________________

City __________________ State ___________ Zip _____________ Home Phone ______________________

Birth Date _______/_______/_______ Age ________ Sex: M /F Height _________ Weight _____________

School/Occupation _____________________________ Email Address _____________________________________

Are you happy with your smile? **Yes/ No (CIRCLE ONE)**

Are you interested in whitening your teeth? **YES OR NO (CIRCLE ONE)**

How did you hear about our office? ___________________________________________________________

## Medical Information

Are you currently under the care of a physician Yes/No Name of physician: ___________________________________

Phone _______________________________________________________

Does the patient have or has he/she had any of the following conditions? **(CIRCLE Y/N)**

**Y/ N** Diabetes

**Y/ N** Stroke

**Y/ N** Asthma

**Y/ N** Hepatitis or Liver disease

**Y/ N** Tonsillitis

**Y/ N** AIDS, HIV +

**Y/ N** Cancer/Chemotherapy

**Y/ N** Stroke

**Y/ N** Difficulty Breathing

**Y/ N** Fainting Spells,Seizures

**Y/ N** Rheumatic/ Scarlet Fever

**Y/ N** Allergies(Medicine or other)

**Y/ N** Latex or Nickel Sensitivity/Allergy

**Y/ N** High or Low Blood Pressure

Y/ N Epilepsy

Y/ N Emphysema

Y/ N Heart Defect, Heart Murmur, Heart Disease

**Y/ N** Herpes, Fever Blisters

**Y/ N** Joint Replacement/Implant

**Y/ N** Drug or Alcohol Dependence

**Y/ N** Tonsils/Adenoids Removed

**Y/ N** Anemia

**Y/ N** Excessive Bleeding/Bruising

**Y/ N** Hospitalized for any Reason

Do you Smoke or use tobacco in any other form? **Yes/ No**

Do you have any history of substance abuse? **Yes/No**

Do you have any drug allergies? **Yes/ No**

List: ________________________________________________________________________________

Do you take any blood thinners? **Yes/ No**

Do you, now or have ever taken any medications for your bones, Ex: bisphosphonates, Fosamax, Boniva, Actonel, or Zometa? If so, which drug? ______________________________________________________________

If female, has she begun menstruating? **Yes/ No** If yes at what age?____yrs

Are you pregnant? **Yes/No** What trimester are you in?_____

Do you have a disease, condition, or problem not listed that you think we should know about?

Please Explain: _______________________________________________

Are you taking any prescription/ over-the-counter drugs at this time? **Yes/No**

list _________________________________

**Dental Health Information**

Are you experiencing any dental problems, pain or discomfort? **Yes/ No** Date Of Last Dental visit: _____/_____/_______

Most recent dentist ___________________ Address ________________________________________ Phone______________

Have you ever had a serious/ difficult problem associated with any previous dental work? **Yes/ No**

Do you require antibiotics/premedications before dental treatment? **Yes/ No**

**Does the patient have or has he/she had any of the following diseases or problems? (CIRCLE Y/N )**

**Y/ N** Tongue Thrust **Y/ N** Jaw Pain ( Joint Ear, Side of Face)

**Y/ N** Sore or Bleeding Gums **Y/ N** Tooth Sensitivity to Heat, Cold or Sweats

**Y/ N** Permanent Tooth Extraction **Y/ N** Any Loose Teeth

**Y/ N** Difficulty Chewing **Y/ N** Extra Permanent Teeth

**Y/ N** Gum Treatment in the Past **Y/ N** Fear of Dental Work

**Y/ N** Previous Orthodontic Treatment **Y/ N** Clenching or Grinding

**Y/ N** Clicking or Popping of the Jaw Joints
**Y/ N** Head/ Neck, Jaw or Tooth Injury

**Dental Insurance Information**

Primary Insurance Company Name __________________________ Employer Name __________________________

Phone # ___________________________________ ID#___________________________________

Address______________________________________________________________________________________________

Group/Plan Number ________________________________________________________________________

Primary Policy Holder Name ______________________________________Social Security Number _____-_____-_____

Date of Birth ________/_________/__________

**Responsible Party Information**

Name___________________________________ Phone # ___________________________________ Email

Address__________________________________________ Date of Birth _____/_____/_____

**I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in the patient's medical status.**

Signature of Patient/Guardian ______________________________________________ Date ________________________

Doctor's Signature ____________________________________________________Date __________________________