



TODAY'S DATE: \_\_\_\_\_

**PATIENT INFORMATION**

Mr.     Ms.     Mrs.     Dr.  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/Postal Code: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_  Male  Female  
Month Day Year  
 In Case of Emergency Please Contact: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Who can we thank for referring you? \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance** – Name of insured: \_\_\_\_\_  
 Insurance company: \_\_\_\_\_  
 Policy# \_\_\_\_\_ Cert# \_\_\_\_\_ Div# \_\_\_\_\_  
 Relation:  Self  Spouse  Other Birth Date: \_\_\_/\_\_\_/\_\_\_  
Month Day Year  
**Secondary Insurance** – Name of insured: \_\_\_\_\_  
 Insurance company: \_\_\_\_\_  
 Policy# \_\_\_\_\_ Cert# \_\_\_\_\_ Div# \_\_\_\_\_  
 Relation:  Self  Spouse  Other Birth Date: \_\_\_/\_\_\_/\_\_\_  
Month Day Year

**PERSON RESPONSIBLE FOR ACCOUNT**

Self     Spouse     Parent     Guardian     Other  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_  Male  Female  
Month Day Year

**HISTORY**

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Previous Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Last Dental X-Rays: \_\_\_\_\_  
 Last Cleaning: \_\_\_\_\_  
 Previous problems with Dental Tx: \_\_\_\_\_  
 Are you satisfied with the appearance of your teeth?  
 Y  N  Explain: \_\_\_\_\_

**PAST HISTORY**

Y  N  Gum Surgery?  
 Y  N  Orthodontics (Braces)  
 Y  N  Endodontics (Root Canal)  
 Y  N  Oral Surgery

- Wisdom teeth removal
- Dental Implants
- Crowns
- Bridges
- Dentures

**EMPLOYMENT INFORMATION**

Employer: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ EXT: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Union Local: \_\_\_\_\_

**PLEASE CHECK ALL DENTAL CONCERNS THAT APPLY TO YOU:**

**TEETH**

- Broken/Chipped/Cracked
- Missing Tooth or Teeth
- Decay
- Loose Teeth
- Mouth Breathing
- Difficulty Chewing
- Food Trap Areas
- Grinding or Clenching
- Oral Habits: \_\_\_\_\_

- Mouth Sores
- Sensitive to Hot/Cold
- Sensitive to Sweets
- Tooth Pain
- Sinus Problems
- Burning Tongue/Lips/ Dry Mouth
- Gum Surgery
- Shifting teeth

**GUMS**

- Bleeding/Sore Gums
- Bad Breath
- Sore or Sensitive
- Swelling or Lumps

**Jaw/Facial Pain Problems**

- Facial Pain
- Frequent Headaches
- Jaw Clicks
- Pain in Cheeks or Temples
- Difficulty Opening

**OTHER CONCERNS OR REASONS FOR VISIT:**

\_\_\_\_\_

\_\_\_\_\_



## HEALTH HISTORY

This information will be kept strictly confidential and will be used by the dentist to assist in providing optimum treatment. If you have any questions or concerns, our staff will be pleased to assist you.

**Y N**

- Are you presently in good health?
- Do you use any tobacco products or nicotine substitutes? Type/Frequency: \_\_\_\_\_
- Past surgeries or hospitalizations: \_\_\_\_\_
- Are you taking any medications (prescription or herbal)? Type: \_\_\_\_\_
- Do you have any allergies? \_\_\_\_\_

## GENERAL

**Do you presently have or have you ever had any of the following conditions?**

**Y N**

- Artificial Joints: \_\_\_\_\_
- Auto Immune Disease
- Asthma
- Blood Pressure  High  Low
- Bleeding Disorder
- Cancer: \_\_\_\_\_
- Diabetes:  Type I  Type II
- Epilepsy
- Fainting
- HIV/AIDS
- Hepatitis  A  B  C
- Heart Murmur
- Other** \_\_\_\_\_

**Y N**

- Heart Disorders/Disease
- Mitral Valve Prolapse
- Artificial Heart Valves
- Pacemaker
- Osteoporosis
- Rheumatic Fever
- Scarlet Fever
- Thyroid Disorders
- Are you pregnant?
- Injury to:  Face  Mouth  
 Neck  Teeth
- Chemotherapy/ radiation therapy

## SLEEPING HABITS

**Y N**

- Do you have Sleep Apnea?
- Is your sleep unrefreshing or of poor quality?
- Do you have trouble sitting and talking to someone?
- Are you told that you snore?
- Do you choke, gasp or snort during sleep?
- Do you have trouble sitting, inactive in a public place?

**Y N**

- Do you have trouble sitting, reading or watching television? (not at bedtime)
- Do you fall asleep in a car, while stopped For a few minutes in traffic?
- Do you ever walk or talk in your sleep

**PLEASE NOTE: WE REQUIRE 48 HOURS NOTICE UPON CANCELLATION OF APPOINTMENTS. A FEE OF \$50 FOR HYGIENE OR \$ 75 FOR DENTIST FOR NO SHOW / MISSED APPOINTMENTS WILL BE CHARGED TO YOUR ACCOUNT.**

**Patient Release:** I certify that I have provided an accurate and complete medical and dental history for myself (or my dependant) and have not omitted any information. I have had the opportunity to ask questions and have received answers regarding any concerns I have regarding my dental treatment. I authorize the dentist to consult with my physician (or specialist) regarding any compromising medical condition in my (or my dependants) medical/dental history. I have also read and understand the Privacy Act given to me to review.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  Patient  Parent  Guardian  
Reviewed by: \_\_\_\_\_