PLEASE FILL OUT ALL INFORMATION COMPLETELY

First Name _____ *Last Name* _____ *M.I.*_____
Nickname _____ *Birth Date* _____
Address _____ *Soc. Sec. #* _____
City _____ *State* _____ *Zip* _____
Home # _____ *Work #* _____ *Cell #* _____

PLEASE CIRCLE: ADULT SINGLE MARRIED DIVORCED WIDOWED CHILD MALE FEMALE
EMERGENCY CONTACT _____ *PHONE #* _____
IF MARRIED: Spouse's Name _____ *Birth Date* _____

Employer Name _____
Address _____

IF CHILD: Mother's Name _____
Address & Phone # (IF DIFFERENT) _____
_____
Father's Name _____
Address & Phone # (IF DIFFERENT) _____
_____

PRIMARY DENTAL INS.
Employee _____
Employer _____
Ins. Company _____
I.D. # _____
Group Plan # _____
Subscriber Birth date _____

SECONDARY DENTAL INS.
Employee _____
Employer _____
Ins. Company _____
I.D. # _____
Group Plan # _____
Subscriber Birth date _____

Date of last dental exam _____ *Last X-rays* _____ *Cleaning*_____
What type of toothbrush do you use? Please circle. SOFT/MEDIUM/HARD/ELECTRIC
How many times a day do you brush? _____ *Floss?* _____
Do you use tobacco? _____ *What type?* _____ *How often?* _____
Are you experiencing any dental pain? _____ *Where?* _____
Have you ever been hospitalized? Please explain. _____
_____
Are you taking any medications including prescription, over the counter, herbal supplements, & vitamins? Please list. _____
_____
_____
Are you allergic to anything including medications? (Ex:Latex,Penicillin) Please list.
_____

PLEASE COMPLETE OPPOSITE SIDE

Are you currently taking anti-coagulants (blood thinners)? (Ex:Plavix) _____
Do you have any mental or physical disabilities? Please explain. _____
_____
Have you ever had cancer or a tumor? What type? _____ *When?* _____
Are you undergoing radiation, chemotherapy, or other treatment? _____

WOMEN PLEASE CIRCLE: PREGNANT NURSING TAKING CONTRACEPTIVES
Are you currently taking Bisphosphonates? (Ex:Fosamax) List _____

Please circle YES or NO INDIVIDUALLY for all of the following that you may have currently or had in the past. IF YES PLEASE EXPLAIN!

Heart failure	*Y*	*N*	*Diabetes/type* _____	*Y*	*N*
Heart disease/attack	*Y*	*N*	*Hepatitis/type* _____	*Y*	*N*
When? _____			*Blood transfusion*	*Y*	*N*
Stroke	*Y*	*N*	*Alcohol/drug addiction*	*Y*	*N*
When? _____			*Cold sore (herpes)*	*Y*	*N*
Angina (chest pain)	*Y*	*N*	*Fainting/dizziness*	*Y*	*N*
Heart pacemaker	*Y*	*N*	*Epilepsy/seizures*	*Y*	*N*
Heart surgery	*Y*	*N*	*Nervousness/anxiety*	*Y*	*N*
When? _____			*Emphysema*	*Y*	*N*
Heart murmur	*Y*	*N*	*Anemia*	*Y*	*N*
Mitral valve prolapse	*Y*	*N*	*Asthma*	*Y*	*N*
Congenital heart lesions	*Y*	*N*	*Sinus trouble*	*Y*	*N*
Artificial heart valve	*Y*	*N*	*Allergies/hives*	*Y*	*N*
Rheumatic fever	*Y*	*N*	*Kidney trouble*	*Y*	*N*
Artificial joint	*Y*	*N*	*Arthritis*	*Y*	*N*
What/when? _____			*Liver disease*	*Y*	*N*
SBE (bacterial infection)	*Y*	*N*	*AIDS/HIV*	*Y*	*N*
High blood pressure	*Y*	*N*	*Thyroid disease*	*Y*	*N*
Cadaver part placement	*Y*	*N*	*Hyper/hypo?* _____		
Tuberculosis (TB)	*Y*	*N*	*Bruise easily*	*Y*	*N*
Pain in jaw (TMJ)	*Y*	*N*	*STD's*	*Y*	*N*

Please include any other medical information that may not be mentioned above.
_____
_____
_____

I have answered all above questions to the best of my knowledge.

Date: _____ *Signature of patient/parent/guardian* _____

PLEASE RETURN TO RECEPTIONIST UPON COMPLETION!