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Family and Restorative Dentistry
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Welcome to our office

❖ **Patient Information**

Name (Last, First MI): _____ Birthdate: ____/____/____
I prefer to be called: _____ E-mail: _____
Street Portion of Mailing Address: _____
City, State: _____ Zip Code: _____ Home # _____
Employer: _____ Work # _____ Mobile # _____
Location of Employer (City & State): _____ Occupation: _____
Social Security # _____ Driver License # _____ State: _____
Marital Status (check one): Single Married Separated Divorced Widowed Other
Spouse's Name (Last, First MI): _____ Birthdate: ____/____/____
Spouse's Employer: _____ Work # _____
Emergency Contact (Name and Telephone): _____

❖ **Head of Household Information**

Name of Person Responsible for Account (Last, First MI): _____
Birthdate: ____/____/____ Social Security # _____ Relationship to Patient: _____
Street Portion of Mailing Address (if different): _____
City, State: _____ Zip Code: _____ Home # _____
Employer: _____ Work # _____ Mobile # _____
Location of Employer (City & State): _____ Driver License # _____ State: _____

❖ **Insurance Information**

Do you currently have dental insurance? Yes No (**If yes, please complete this section)
Subscriber Name (Last, First MI): _____
Subscriber Birthdate: ____/____/____ Social Security # _____ Relationship to Patient: _____
Insurance Company: _____ Telephone # _____
Employer: _____ Group # _____

❖ **Medical History**

Have you ever had or do you currently have any of the following? (please check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Anxiety/Nervous Disorder | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alcohol/Drug Addiction | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Back/Neck Problems | <input type="checkbox"/> Hemophilia/Excessive Bleeding | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> Hepatitis, Type ____ | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> HIV/AIDS Test Positive | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herpes/Cold Sores | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Head Injury/Mental Disorder | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Venereal Disease |

Please list any other conditions not listed above: _____

Are you allergic or have you ever reacted adversely to any of the following? (please check all that apply)

- | | | | |
|--------------------------------------|---|--|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Hydrocodone | <input type="checkbox"/> Valium |

Please list any other allergies not listed above: _____

Do you smoke or chew tobacco? Yes No **If yes, how much? _____

Physician's Name: _____ Telephone # _____

Date of Last Physical Examination: ____/____/____ Are you currently taking medication? Yes No

**If yes, please list: _____

Have you been hospitalized in the past two years? Yes No

**If yes, for what reason? _____

Are you currently under the care of a physician for a specific condition? Yes No

**If yes, please describe: _____

FOR WOMEN

Are you pregnant? Yes No **If yes, how many months? _____

Are you taking birth control pills? Yes No

❖ Dental History

Name of Previous/Present Dentist: _____ Date of Last Visit: _____

Location of this Dentist (City & State): _____ Telephone # _____

**Is there anything particular that you liked or disliked about your previous dentist or his office? _____

How did you hear about us? (friend, yellow pages, sign, etc.) _____

How many times a day do you brush your teeth? _____ How often do you floss? _____

Are you currently in dental-related pain? Yes No Do you frequently experience jaw pain? Yes No

Do you have difficulty becoming numb for dental treatment? Yes No Unsure

Do you have dental-related anxiety? Yes No

Are you happy with the appearance of your smile? Yes No

**If no, please tell us what you would like to change (color, shape, alignment, etc.): _____

Please number the following in the order in which each would keep you from having dental treatment:

__ Fear of pain __ Cost of treatment __ Lack of concern __ Missing work time

❖ Consent for Treatment

The undersigned, (print name) _____, hereby confirms that the above information is correct to the best of his/her knowledge. I understand that the information given will be used by the doctor to help determine appropriate and healthful dental treatment for this patient. If there is any change in this patient's medical status, I agree to inform the dentist or a member of his staff. Furthermore, I authorize the doctor to take x-rays, photographs, study models, and/or any other diagnostic aids he deems appropriate in order to make a thorough diagnosis of this patient's dental needs. I also authorize the doctor to choose and employ such assistance as he deems fit. I give my consent for the doctor to use any and all forms of treatment and therapy necessary, including prescribing or administering medications that may be indicated in connection with this patient, to be determined and discussed on an appointment-to-appointment basis. I understand that the use of anesthetic agents embodies a certain risk.

Patient Signature (Parent or Guardian Signature)

Date