# PATIENT INFORMATION FORM

Please Complete All Entries

| Minor or Dependent Patient: Name (Last - First - Middle) | Sex M F | Date of Birth | Age | For Office Use Only |
|---|---|---|---|---|
| | | | | |

| Adult Patient: Name (Last - First - Middle) (Or Parent / Guardian of Dependent Named Above) | Date of Birth | Age | Social Security Number |
|---|---|---|---|
| | | | |

| Address (Street - City - State - Zip) | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated |
|---|---|
| | Driver's License Number |
| | Home Phone Number ( ) |

| Name of Employer | Occupation | Work Phone Number |
|---|---|---|
| | | ( ) |

| Employer's Address (Street - City - State - Zip) |
|---|
| |

| Name of Spouse (Last - First - Middle) | Date of Birth | Age | Social Security Number |
|---|---|---|---|
| | | | |

| Spouse's Employer | Spouse's Work Phone No. |
|---|---|
| | ( ) |

| Family Physician | Phone No. |
|---|---|
| | ( ) |

| Family Dentist | Phone No. |
|---|---|
| | ( ) |

| Nearest Relative Not Living With You | Phone No. |
|---|---|
| | ( ) |

| Nearest Friend Not Living With You | Phone No. |
|---|---|
| | ( ) |

| In Case of Emergency, Notify | Emergency Phone No. |
|---|---|
| | ( ) |

| In Case of Emergency, Notify Landlord (if renting) | Landlord's Phone No. |
|---|---|
| | ( ) |

| Who / What Referred You to Our Facility? | Phone No. |
|---|---|
| | ( ) |

| Who is Financially Responsible for Payment? | I Prefer to Pay With: ☐ Cash ☐ Check ☐ Visa ☐ Mastercard |
|---|---|
| | |

## INSURANCE INFORMATION

| Primary Insurance Name | Address (City - State - Zip) | | Phone No. |
|---|---|---|---|
| | | | ( ) |
| Name of Insured | Relationship | I.D. No. | Group No. |
| | | | |
| Secondary Insurance Name | Address (City - State - Zip) | | Phone No |
| | | | ( ) |
| Name of Insured | Relationship | I.D. No. | Group No. |
| | | | |

I Understand and Agree That I Am Ultimately Responsible For Payment.
I Certify This Information is True and Correct to the Best of My Knowledge.

Signature _____ Date _____

Date _____

Name _____ Residence _____
Last First M. In.

Date of Birth _____

Physician _____ Office Phone _____

Approximate date of last physical examination _____

| | YES | NO |
|---|---|---|
| 1. Are you under any medical treatment now? | ☐ | ☐ |
| 2. Have you had any major operations? If so what? | ☐ | ☐ |
| 3. Have you ever had a serious accident involving head injuries? | ☐ | ☐ |
| 4. Have you had any adverse response to any drugs including penicillin? | ☐ | ☐ |
| 5. Has a physician ever informed you that you had: A Heart Ailment? | ☐ | ☐ |
| 6. High Blood Pressure? | ☐ | ☐ |
| 7. Respiratory disease? | ☐ | ☐ |
| 8. Diabetes? | ☐ | ☐ |
| 9. Rheumatic fever? | ☐ | ☐ |
| 10. Rheumatism or arthritis? | ☐ | ☐ |
| 11. Tumors or growths? | ☐ | ☐ |
| 12. Any blood disease? | ☐ | ☐ |
| 13. Any liver disease? | ☐ | ☐ |
| 14. Any kidney disease? | ☐ | ☐ |
| 15. Any stomach or intestinal disease? | ☐ | ☐ |
| 16. Any venereal disease? | ☐ | ☐ |
| 17. Yellow jaundice or hepatitis? | ☐ | ☐ |
| 18. Are you on a diet at this time? | ☐ | ☐ |
| 19. Are you now taking drugs or medications? | ☐ | ☐ |
| 20. Are you allergic to any know materials resulting - in hives, asthma, eczema, etc.? | ☐ | ☐ |
| 21. Are you in general good health at this time? | ☐ | ☐ |
| 22. Have any wounds healed slowly or presented other complications? | ☐ | ☐ |
| 23. Are you pregnant? | ☐ | ☐ |
| 24. Do you have a history of fainting? | ☐ | ☐ |
| 25. Have you ever had an X-RAY TREATMENTS (other than diagnostic)? | ☐ | ☐ |
| 26. Have you ever been exposed to the HIV virus that causes AIDS? | ☐ | ☐ |
| 27. Are you HIV positive? | ☐ | ☐ |
| 28. Do you have AIDS? | ☐ | ☐ |

## PATIENT DENTAL HISTORY

| | | |
|---|---|---|
| 29. Are you happy with your smile? | ☐ | ☐ |
| 30. Do you have pain in or near your ears? | ☐ | ☐ |
| 31. Do you have any unhealed injuries or inflammed areas in or around your mouth? | ☐ | ☐ |
| 32. Have you experienced any growth or sore spots in your mouth? | ☐ | ☐ |
| 33. Does any part of your mouth hurt when clenched? | ☐ | ☐ |
| 34. Have you ever had Novocaine anesthetic? | ☐ | ☐ |
| 35. Any reaction sor allergic symptoms to novocaine? | ☐ | ☐ |
| 36. Any difficult extractions in the past? | ☐ | ☐ |
| 37. Prolonged bleeding following extractions in the past? | ☐ | ☐ |
| 38. Do your gums bleed? | ☐ | ☐ |
| 39. Have you ever had instruction on the correct method of brushing your teeth? | ☐ | ☐ |
| 40. Have you ever had instructions on the care of your gums? | ☐ | ☐ |
| 41. Do you chew on only one side of your mouth? If so why? | ☐ | ☐ |
| 42. Do you at the present time have any dental complaints? | ☐ | ☐ |
| 43. Do you habitually clench your teeth during the night or day? | ☐ | ☐ |
| 44. When was your last full mouth X-RAY taken? _____ Where? _____ | ☐ | ☐ |
| 45. Any part of your mouth sore to pressures or irritants (cold,sweets, etc.) | ☐ | ☐ |

If so locate _____

Signature _____