

## About you...

Mr.  Mrs.  Ms.  Dr.

First Name:

Last Name:

Birth Date:  (m) /  (d) /  (y)

SSN#:  -  -

Address:

City:

State:  Zip:

single  married  divorced  widowed  separated

Home Phone: (  )  -

Mobile Phone: (  )  -

Work Phone: (  )  -

Email:

Occupation:

Employer:

How did you hear about us?

Who may we thank for referring you?

## More about you...

Spouse/Partner:

First Name:

Last Name:

Children (#):

What are their names?:

Pets (#):   
(we care about them too)

Personal Interests:

Athletic Interests:

Favorite Music:

Favorite Food:

Favorite Movie(s):

## About your benefits...

Primary Dental Insurance

Name of Insurance:

Group # (plan, local, or policy #):

Address:

  

Phone:

 (  )  - 

First Name:  
(of insured)

Last Name:  
(of insured)

Relation to insured:

Birth Date:  
(of insured)

 (m) /  (d) /  (y)

SSN#:  
(of insured)

 -  - 

Insured's Employer:

### Secondary Dental Insurance

Name of Insurance:

Group # (plan, local, or policy #):

Address:

  

Phone:

 (  )  - 

First Name:  
(of insured)

Last Name:  
(of insured)

Relation to insured:

Birth Date:  
(of insured)

 (m) /  (d) /  (y)

SSN#:  
(of insured)

 -  - 

Insured's Employer:

## About what we can do for you...

How can we help you today?

Are you in any pain or discomfort?

When was your last dental visit?

What do you like about your smile?

What don't you like about your smile?

## About your physician...

First Name:

Last Name:

When was your last visit?

How would you rate your current physical health?  excellent  fair  poor

Are you currently being treated for any condition?  yes  no

If yes, explain:

## For women...

Are you taking birth control?  yes  no

Are you pregnant?  yes  no

If yes, when are you due?

 (m) /  (d) /  (y)

Are you nursing?  yes  no

## About your health...

Have you had any of the following diseases, conditions, or treatments?  (set all to "no")

- |                              |                          |                              |                       |                              |                       |
|------------------------------|--------------------------|------------------------------|-----------------------|------------------------------|-----------------------|
| <input type="checkbox"/> yes | Abnormal Bleeding        | <input type="checkbox"/> yes | Frequent Headaches    | <input type="checkbox"/> yes | Mitral Valve Prolapse |
| <input type="checkbox"/> no  |                          | <input type="checkbox"/> no  |                       | <input type="checkbox"/> no  |                       |
| <input type="checkbox"/> yes | Alcohol/Drug Abuse       | <input type="checkbox"/> yes | Glaucoma              | <input type="checkbox"/> yes | Pacemaker             |
| <input type="checkbox"/> no  |                          | <input type="checkbox"/> no  |                       | <input type="checkbox"/> no  |                       |
| <input type="checkbox"/> yes | Anemia                   | <input type="checkbox"/> yes | Hay Fever             | <input type="checkbox"/> yes | Psychiatric Problems  |
| <input type="checkbox"/> no  |                          | <input type="checkbox"/> no  |                       | <input type="checkbox"/> no  |                       |
| <input type="checkbox"/> yes | Arthritis                | <input type="checkbox"/> yes | Heart Attack          | <input type="checkbox"/> yes | Radiation Therapy     |
| <input type="checkbox"/> no  |                          | <input type="checkbox"/> no  |                       | <input type="checkbox"/> no  |                       |
| <input type="checkbox"/> yes | Artificial Joints/Valves | <input type="checkbox"/> yes | Heart Murmur          | <input type="checkbox"/> yes | Rheumatic Fever       |
| <input type="checkbox"/> no  |                          | <input type="checkbox"/> no  |                       | <input type="checkbox"/> no  |                       |
| <input type="checkbox"/> yes | Asthma                   | <input type="checkbox"/> yes | Heart Surgery         | <input type="checkbox"/> yes | Seizures              |
| <input type="checkbox"/> no  |                          | <input type="checkbox"/> no  |                       | <input type="checkbox"/> no  |                       |
| <input type="checkbox"/> yes | Blood Transfusion        | <input type="checkbox"/> yes | Hemophilia            | <input type="checkbox"/> yes | Shingles              |
| <input type="checkbox"/> no  |                          | <input type="checkbox"/> no  |                       | <input type="checkbox"/> no  |                       |
| <input type="checkbox"/> yes | Cancer                   | <input type="checkbox"/> yes | Hepatitis             | <input type="checkbox"/> yes | Sickle Cell Disease   |
| <input type="checkbox"/> no  |                          | <input type="checkbox"/> no  |                       | <input type="checkbox"/> no  |                       |
| <input type="checkbox"/> yes | Colitis                  | <input type="checkbox"/> yes | Herpes/Fever Blisters | <input type="checkbox"/> yes | Sinus Problems        |

<input type="checkbox"/> no		<input type="checkbox"/> no		<input type="checkbox"/> no	
<input type="checkbox"/> yes	Congenital Heart Ds	<input type="checkbox"/> yes	High Blood Pressure	<input type="checkbox"/> yes	Stroke
<input type="checkbox"/> no		<input type="checkbox"/> no		<input type="checkbox"/> no	
<input type="checkbox"/> yes	Diabetes	<input type="checkbox"/> yes	HIV/AIDS	<input type="checkbox"/> yes	Thyroid Problems
<input type="checkbox"/> no		<input type="checkbox"/> no		<input type="checkbox"/> no	
<input type="checkbox"/> yes	Difficulty Breathing	<input type="checkbox"/> yes	Hospitalized ever?	<input type="checkbox"/> yes	Tuberculosis (TB)
<input type="checkbox"/> no		<input type="checkbox"/> no		<input type="checkbox"/> no	
<input type="checkbox"/> yes	Emphysema	<input type="checkbox"/> yes	Kidney Problems	<input type="checkbox"/> yes	Ulcers
<input type="checkbox"/> no		<input type="checkbox"/> no		<input type="checkbox"/> no	
<input type="checkbox"/> yes	Epilepsy	<input type="checkbox"/> yes	Liver Disease	<input type="checkbox"/> yes	Veneral Disease
<input type="checkbox"/> no		<input type="checkbox"/> no		<input type="checkbox"/> no	
<input type="checkbox"/> yes	Fainting Spells	<input type="checkbox"/> yes	Low Blood Pressure	<input type="checkbox"/> yes	Do you smoke?
<input type="checkbox"/> no		<input type="checkbox"/> no		<input type="checkbox"/> no	

Please list any other serious medical conditions you have had:

## About your medications and any allergies...

Are you taking any prescribed or over-the-counter medications?  yes  no

If yes, please list:

Do you have any allergies?  yes  no

If yes, please list:

Have you ever had an adverse reaction to any of the following:

- aspirin  latex  codeine  penicillin  anesthetics  antibiotics  
 ibuprofen

Please explain any other medications or issues we should be aware of: