Patient Chart #_____
Date_____

PATIENT INFORMATION

Name:_____Preferred Name:_____DOB:_____
Last First Middle (No initials)
Home Phone:_____Cell Phone:_____
Mailing Address _____
City:_____ State:_____ Zip:_____
Patient's Social Security Number: _____-_____-_____
Patient Employer:_____Work Phone:_____

Sex: Male / Female Married Widowed Single Minor
Separated Divorced Partner

E-Mail:_____ School Attending if Student:_____
Spouse or Parent's Name:_____
Spouse or Parent's Employer:_____Occupation:_____
Person to contact in case of Emergency:_____Phone:_____

RESPONSIBLE PARTY

Name of Person Responsible for this Account:_____
Relation to Patient:_____Birth Date:_____Home Phone:_____
Address:_____
Employer:_____Work Phone:_____
Social Security #:_____Drivers License #_____

REFERRAL

Patient referred by:_____
Reason for visit:_____
Name of your Dentist:_____ Address & Phone:_____
Name of Physician:_____ Address & Phone:_____

DENTAL INSURANCE INFORMATION

Subscriber:_____Relation to Patient:_____Phone:_____
Subscriber's address if different from patient's:_____
Date of Birth:_____Social Security # or ID#_____
Employer:_____
Insurance Company:_____
Insurance Address:_____
Insurance Phone:_____Group #_____

ADDITIONAL DENTAL INSURANCE

Subscriber:_____Relation to Patient:_____Phone:_____
Subscriber's address if different from patient's:_____
Date of Birth:_____Social Security # or ID#_____
Employer:_____
Insurance Company:_____
Insurance Address:_____
Insurance Phone:_____Group #_____

X_____ _____
Signature of Insured Person or Responsible Party **Date**

Name: _____ , _____ Chart # _____
Last First Middle (no initials) (Office Use Only)

CURRENT DENTAL HISTORY

Last Dental Treatment _____ Last Cleaning _____ How Often? _____

Deep Cleaning with Anesthetic? _____

Symptoms: ____ Pain ____ Bleeding ____ Taste ____ Odor ____ Loose teeth ____ Migrating teeth ____ Sensitive Teeth

Toothbrush: ____ Electric (Sonicare, Oral-B) ____ Manual ____ Hard ____ Medium ____ Soft

Cleaning Aids: ____ Floss ____ Proxy Brush ____ Stimulator ____ Toothpicks ____ Water-Pik ____ Mouthwash ____ Softpicks

MEDICAL HISTORY - Current or have you ever had

(Check all that apply)

Dental Issues

- ☐ Reaction to dental anesthetic
- ☐ Latex allergy
- ☐ Take pre-medication prior to dental visits
- ☐ Facial pain
- ☐ Sinus problems
- ☐ Sore TMJ
- ☐ Popping TMJ
- ☐ Fear dental treatment
- ☐ Are you happy with your smile? (Y/N)

Treatment for Periodontal Disease

- ☐ Prior periodontal treatment
- ☐ Scaling & Root Planing (deep cleaning)
- ☐ Osseous surgery
- ☐ Dental implants
- ☐ Gum grafting
- ☐ Laser treatment

Smoking

- ☐ Cigarettes, cigars
- ☐ Smokeless tobacco
- ☐ E-Cigarettes

Heart Issues

- ☐ High blood pressure
- ☐ Chest pains (angina)
- ☐ Heart attack or stroke
- ☐ Valve replacement
- ☐ Pacemaker/defibrillator
- ☐ Stents
- ☐ Rheumatic fever
- ☐ Arrhythmia
- ☐ Heart murmur

Lung Issues

- ☐ Emphysema
- ☐ Asthma
- ☐ Persistent cough
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Hay fever

Bleeding Issues

- ☐ Take aspirin
- ☐ Take blood thinner
- ☐ Prolonged bleeding
- ☐ Anemia or hemophilia
- ☐ Bruise easily
- ☐ Glaucoma

Systemic Conditions

- ☐ Fainting or dizziness
- ☐ Epilepsy or seizures
- ☐ Liver disease/Jaundice
- ☐ Hepatitis (A, B, C)
- ☐ Stomach disorders/Ulcers
- ☐ Thyroid/Endocrine/Hormonal disease
- ☐ Type I Diabetes (A1C = ___)
- ☐ Type II Diabetes (A1C = ___)
- ☐ Bone disorder
- ☐ Kidney disease
- ☐ Skin rashes or hives
- ☐ HIV / AIDS / STDs
- ☐ Autoimmune disease
- ☐ Artificial joints
- ☐ Drug abuse or addition
- ☐ Alcohol abuse or addiction
- ☐ Cancer or tumor
- ☐ Radiation therapy
- ☐ Chemotherapy
- ☐ Vitamins or herbal supplements

Women

- ☐ Pregnant now
- ☐ Plan on becoming pregnant
- ☐ Currently taking contraceptives
- ☐ Entered menopause
- ☐ Anti-Osteoporosis medication

What is your present health? Good Fair Poor

Yes No

☐ ☐ Are you ALLERGIC to any medication, drugs, or substance? Specify: _____

☐ ☐ Have you seen a physician during the last 2 years? Specify: _____

☐ ☐ Do you have or have you ever had any diseases, conditions, or problems not listed above? Specify: _____

☐ ☐ Have you ever been hospitalized or had surgery? Specify: _____

☐ ☐ Are you presently taking any medications or drugs? Specify (print): _____

BP _____

_____ _____
Signature Date