About You:

Name: _____ Age: _____ D.O.B: _____ Sex: _____

Address: _____ City: _____ Zip: _____

Home #: _____ Cell #: _____ Text Messages OK? Y☐ N☐

SS #: _____ Marital Status: _____ Email: _____

Employer: _____ Employer Phone #: _____

Emergency Contact: _____ Phone #: _____

Preferred Pharmacy: _____ Pharmacy Phone #: _____

Spouse Name: _____ Phone #: _____

How did you hear about us? _____ If referred, who can we thank? _____

Insurance Information:

Name of Carrier: _____ Name of Insured: _____ Relation: _____

SS #: _____ D.O.B: _____ Group Number: _____

Do you have secondary Coverage? Y☐ N☐ (If yes, please complete secondary information below)

Name of Carrier: _____ Name of Insured: _____ Relation _____

SS #: _____ D.O.B: _____ Group Number: _____

Medical Information:

Do you have a primary care physician? Y☐ N☐ If yes, who? _____

Are you currently taking any medications? Y☐ N☐ If yes, please list: _____

Any known allergies? (ex: penicillin, latex, acrylic, metal, anesthetics): Y☐ N☐ If yes, please list below:

Have you recently had surgery in the last 5 years? Y☐ N☐ If yes, please describe below (please include date):

Have you been hospitalized in the last 5 years? Y☐ N☐ If yes, please list details below (please include date):

Do you snore? Y☐ N☐ Do you use any tobacco products? Y☐ N☐

Do you feel rested in the morning? Y☐ N☐ If no, please explain:

Do you have: A sore jaw? Y☐ N☐ Sensitive teeth? Y☐ N☐ Bleeding Gums? Y☐ N☐

Have you recently had a bad dental experience? Y☐ N☐ If yes, please provide details below:

Medical Information…Continued

Do you like your smile? Y☐ N☐ Please explain: _____

Do you have a dental specific problem? Y☐ N☐ If yes, please explain: _____

When was your last dental visit? _____ Have you ever had a serious head or neck injury? Y☐ N☐

If yes, please explain the details: _____

Women: Are you pregnant? Y☐ N☐ Nursing? Y☐ N☐ Taking Oral Contraceptives? Y☐ N☐

To the best of your knowledge, do you have or have you ever had any of the following conditions?

Heart Trouble	Y☐	N☐	Yellow Jaundice	Y☐	N☐	Arthritis/Gout	Y☐	N☐
Heart Murmur	Y☐	N☐	Epilepsy/Seizures	Y☐	N☐	Rheumatoid Arthritis	Y☐	N☐
Irregular Heart Beat	Y☐	N☐	Liver Disease	Y☐	N☐	Psychiatric Care	Y☐	N☐
Chest Pain	Y☐	N☐	Hypoglycemia	Y☐	N☐	Cortisone Medicine	Y☐	N☐
Heart Attack/Failure	Y☐	N☐	Excessive Thirst	Y☐	N☐	Artificial Joint	Y☐	N☐
Congenital Heart	Y☐	N☐	Diabetes	Y☐	N☐	Venereal Disease	Y☐	N☐
Mitral Valve Prolapse	Y☐	N☐	Weight Loss	Y☐	N☐	Alzheimer's Disease	Y☐	N☐
Artificial Heart Valve	Y☐	N☐	Ulcers	Y☐	N☐	Fever Blisters	Y☐	N☐
Blood Disease	Y☐	N☐	Blood Transfusion	Y☐	N☐	Herpes	Y☐	N☐
High Blood Pressure	Y☐	N☐	Hemophilia	Y☐	N☐	Stroke	Y☐	N☐
Low Blood Pressure	Y☐	N☐	Radiation Treatment	Y☐	N☐	Convulsions	Y☐	N☐
Heart Surgery	Y☐	N☐	Excessive Bleeding	Y☐	N☐	Hepatitis	Y☐	N☐
Pacemaker	Y☐	N☐	Chemotherapy	Y☐	N☐	Cold Sores	Y☐	N☐
Scarlet Fever	Y☐	N☐	Easy Bruising	Y☐	N☐	Glaucoma	Y☐	N☐
Rheumatic Fever	Y☐	N☐	Stomach Disease	Y☐	N☐	Asthma	Y☐	N☐
Tumors/Growths	Y☐	N☐	Anemia	Y☐	N☐	Nervousness	Y☐	N☐
Sinus Trouble	Y☐	N☐	Sickle Cell	Y☐	N☐	Jaw Pain	Y☐	N☐
Hay Fever	Y☐	N☐	Cancer	Y☐	N☐	HIV Positive	Y☐	N☐
Frequent Cough	Y☐	N☐	Tuberculosis	Y☐	N☐	AIDS	Y☐	N☐
Shortness of Breath	Y☐	N☐	Emphysema	Y☐	N☐	Genital Herpes	Y☐	N☐
Breathing Problems	Y☐	N☐	Kidney Problems	Y☐	N☐	Allergies	Y☐	N☐
Lung Disease	Y☐	N☐	Renal Dialysis	Y☐	N☐	Drug Addiction	Y☐	N☐
Swelling Limbs	Y☐	N☐	Thyroid Disease	Y☐	N☐	Hives/Rash	Y☐	N☐
Leukemia	Y☐	N☐	Parathyroid Disease	Y☐	N☐	Fainting/Dizziness	Y☐	N☐
Osteoporosis	Y☐	N☐	Other	Y☐	N☐			

I certify that, to the best of my knowledge, I have completed the medical history questionnaire completely and accurately. I also understand that it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

Parent or Legal Guardian (if patient under 18): _____

Relationship to Patient: _____

Parent or Legal Guardian Signature: _____