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Confidential Patient Information

Date _____

Patient's Name _____ Sex M / F
Last First Middle

Address _____
Street City State Zip

Primary Phone _____ Birthdate _____ Social Security # _____

Secondary Phone _____ E-Mail _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Confidential Responsible Party Informa-

Name _____ Marital Status _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Primary Phone _____ Secondary Phone _____ E-Mail _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years Employed _____

Spouse's Name _____
Last First Middle

Employer _____ Occupation _____ No. years Employed _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Insurance Information

Policy Holder's Name _____ Birthdate _____ Soc. Sec. #/ID # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? Yes No If yes:

Policy Holder's Name _____ Birthdate _____ Soc. Sec. #/ID # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Phone _____

Policy Holder's Employer _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

INFORMATION UPDATED: Date _____ Initial _____ INFORMATION UPDATED: Date _____ Initial _____
INFORMATION UPDATED: Date _____ Initial _____ INFORMATION UPDATED: Date _____ Initial _____

Emergency Information

Name of nearest relative not living with you _____

Phone _____ Relationship _____

MEDICAL HISTORY

GENERAL DENTIST _____ LAST CLEANING _____

IS PATIENT IN GOOD HEALTH? _____ YES NO

DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS _____ YES NO

PLEASE LIST _____

CHECK ANY OF THE FOLLOWING FOR WHICH PATIENT HAS BEEN TREATED

- | | | |
|--|---|--|
| AIDS & HIV <input type="checkbox"/> | Anemia <input type="checkbox"/> | Prolonged Bleeding . . . <input type="checkbox"/> |
| Diabetes <input type="checkbox"/> | Epilepsy <input type="checkbox"/> | Fainting or Dizziness . . <input type="checkbox"/> |
| Pneumonia <input type="checkbox"/> | Asthma <input type="checkbox"/> | Nervous Disorders <input type="checkbox"/> |
| Heart Trouble <input type="checkbox"/> | Kidney Involvement . . <input type="checkbox"/> | Hepatitis <input type="checkbox"/> |
| Rheumatic Fever . . <input type="checkbox"/> | Tuberculosis <input type="checkbox"/> | Endocrine Problems . . . <input type="checkbox"/> |
| Bone Disorders . . . <input type="checkbox"/> | | |

DOES PATIENT REQUIRE PRE-MEDICATION PRIOR TO DENTAL VISITS? _____ YES NO

DOES PATIENT HAVE TENDENCY TO COLDS? SORE THROATS? EAR INFECTIONS

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE? _____ YES NO

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASONS _____

LIST ANY ALLERGIES OR DRUG SENSITIVITY _____

HAS THE PATIENT REACHED PUBERTY? — GIRLS - HAS SHE STARTED MENSTRUATION? YES NO

BOYS - HAS HIS VOICE CHANGED? YES NO

HEIGHT _____ WEIGHT _____

DENTAL HISTORY

HAS THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? _____ YES NO

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? _____ YES NO

DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? _____ YES NO

IS THE PATIENT A MOUTH BREATHER? WHILE AWAKE? _____ YES NO

WHILE ASLEEP? _____ YES NO

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? _____ YES NO

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? _____ YES NO

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? _____ YES NO

LIST ANY MUSICAL INSTRUMENTS PLAYED _____

REASON FOR CONSULTATION _____