

# Patient Information / Adult

*The following confidential information is important for the dentist to know in planning your dental care. Please answer each question as completely as you can. Thank you.*

Patient Name		Email
Address		Date of Birth
City, State, Zip		Social Security #
Cell Phone	Home Phone	Marital Status

## Account Information

Employer	Position	Work Phone
Spouse's Full Name		Spouse Date of Birth
Spouse's Employer	Position	Work Phone
Person responsible for account (Address, if different from above)		
Dental Insurance Plan (If any)		Policy Number
Name and phone number of person to contact in case of emergency		
How did you find out about this dental office?		

## Health Information - Dental

Previous Dentist Address	Do any of the following apply to you now or in the past?					
	Toothache	yes	no	Mouth Sores	yes	no
Reason for this visit	Cold Sensitivity	yes	no	Swelling in Mouth	yes	no
	Heat Sensitivity	yes	no	Unpleasant Taste	yes	no
Last dental check-up	Pressure Sensitivity	yes	no	Smoker	yes	no
	Sweet Sensitivity	yes	no	Grinding/Clenching	yes	no
Have you had a complete series of x-rays taken? When?	Bleeding Gums	yes	no	Jaw Joint Noise	yes	no
	Gums Hurt	yes	no	Locked Jaw	yes	no
What do you feel is the present condition of your mouth?	Gum Treatment	yes	no	Improper Bite	yes	no
	Loose Teeth	yes	no	Braces	yes	no
Has anyone ever shown you how to clean your teeth?	Bad Breath	yes	no	Unattractive Teeth	yes	no
	Food Collects	yes	no	Other	yes	no
Are you interested in regular dental care?						
How often do you brush your teeth?						
How often do you floss your teeth?						

# Health Information - Medical

Physician's Name Address / Phone						Are you allergic to:					
Penicillin			yes	no	Local Anesthetic			yes	no		
Codeine			yes	no	Other			yes	no		
Are you presently under the care of a physician? If yes, please explain.						List all medications or drugs (and dosages) that you are taking.					
Have you ever had a serious accident or illness? If yes, please explain.											
(Women) Are you pregnant? If yes, how long?											
Do any of the following apply to you now or in the past?											
Heart Disease	yes	no	Thyroid Problem	yes	no	Tuberculosis, Lung Disease	yes	no	Tumors	yes	no
Rheumatic Fever	yes	no	Jaundice	yes	no	Asthma, Hay fever	yes	no	Glaucoma	yes	no
Heart Murmur	yes	no	Hepatitis	yes	no	Sinus Problems	yes	no	Radiation Therapy	yes	no
Congenital Heart Defect	yes	no	Ulcers	yes	no	Epilepsy Convulsions	yes	no	Prosthetic Implant	yes	no
Abnormal Blood Pressure	yes	no	Diabetes	yes	no	Fainting Spells	yes	no	Venereal Disease	yes	no
Stroke	yes	no	AIDS/HIV	yes	no	Chemical Dependency	yes	no	Arthritis	yes	no
Abnormal Bleeding	yes	no	Anemia	yes	no	Mental Health Care	yes	no	Other	yes	no

The above information is correct to the best of my knowledge. I authorize the administration of such medication and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

D.D.S. Signature \_\_\_\_\_ Date \_\_\_\_\_

Additional Info: \_\_\_\_\_

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