## Insurance Information (Primary)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ____ /____ /_____

Insurance Plan Name: _____ Insurance Co Phone #: _____

Claims Address _____

City, State, Zip _____

Group #: _____ ID #: _____

## Insurance Information (Secondary)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ____ /____ /_____

Insurance Plan Name: _____ Insurance Co Phone #:_____

Claims Address _____

City, State, Zip _____

Group #: _____ ID #: _____

## Employment Information

Employer Name: _____ Phone: _____

Address: _____

City, State, Zip: _____

# Medical History

Patient Name: _____ Date of Birth: _____

1. Date of last physical exam: _____ Physician's Name: _____
Physician's Phone#: _____
2. Have you ever been hospitalized (if yes, explain below)? Yes No
_____
3. Have you been under the care of a medical doctor during the past two years? Yes No
If yes, what for? _____
4. Have you ever had any excessive bleeding requiring special treatment? Yes No
**5. Women:** Are you pregnant/trying to get pregnant/breast feeding? Yes No

6. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

| | | | |
|---|---|---|---|
| Local Anesthetic | Penicillin | Codeine | Other Antibiotic: _____ |
| Latex | Acrylic | Metals | Other:_____ |

7. Are you taking or have you ever taken any of the following medications (please circle if yes):

| | | | |
|---|---|---|---|
| Fosamax | Actonel | Boniva | For how long? _____ |
| Aredia | Reclast | Zometa | When did you stop? _____ |

8. Please list other medications you are taking:
_____
_____

**Have you ever had any of the following?**

| | | | | | |
|---|---|---|---|---|---|
| Chest Pains | Yes No | Shortness of Breath | Yes No | Hives/Skin Rashes | Yes No |
| Heart Failure | Yes No | Ulcers | Yes No | Alcoholism | Yes No |
| Heart Disease | Yes No | Mental Health Issues | Yes No | Herpes | Yes No |
| Heart Attack | Yes No | Emphysema | Yes No | Glaucoma | Yes No |
| Heart Problems | Yes No | Fainting/Dizziness | Yes No | Steroid Treatment | Yes No |
| Angina Pectoris | Yes No | Eating Disorder | Yes No | Arthritis | Yes No |
| Heart Surgery | Yes No | Epilepsy/Seizures | Yes No | Dental Implant | Yes No |
| Liver Disease | Yes No | Persistent Cough | Yes No | Dentures/Partials | Yes No |
| Hypertension | Yes No | Tuberculosis | Yes No | Birth Defects | Yes No |
| Heart Murmur | Yes No | Asthma | Yes No | HIV+, AIDS, ARC | Yes No |
| Rheumatic Fever | Yes No | Hepatitis A | Yes No | Hay Fever | Yes No |
| Sickle cell disease | Yes No | Hepatitis C or D | Yes No | Bruise easily | Yes No |
| Sinus Trouble | Yes No | Pacemaker | Yes No | Jaundice | Yes No |
| Artifical Joints | Yes No | Night Sweats | Yes No | Kidney Trouble | Yes No |
| Thyroid Disease | Yes No | Stroke | Yes No | Diabetes | Yes No |
| Anaemia | Yes No | Drug Addiction | Yes No | Chemotherapy | Yes No |
| Blood Transfusion | Yes No | Cold Sores | Yes No | Cancer | Yes No |
| Mitral Valve Prolapse (MVP) | Yes No | Radiation Therapy | Yes No | Transplant | Yes No |

Patient Signature: _____ Date_____

## Dental History

1. Date of last dental exam:_____ Date of last dental x-rays: _____
2. Previous dentist's name / location:_____
3. Are you having tooth or gum pain at this time? Yes No
4. Do you feel nervous about having dental treatment? Yes No
5. Have you ever had a bad experience in a dental office? Yes No
6. Do your gums bleed when brushing / flossing? Yes No
7. Have you ever seen a periodontist? Yes No
8. Have you ever had a "deep cleaning" (Scaling and Root Planing)? Yes No
9. Is there anything you would like to speak with the Doctor about in private? Yes No
10. Would you be interested in discussing ways to improve your smile? Yes No

If yes, please explain: _____

**Do you have any of the following dental concerns**:

| | | | |
|---|---|---|---|
| Clicking in jaw joint | Yes No | Sensitivity to: Hot | Cold Sweets Biting |
| Pain in or around your ears | Yes No | Swelling | Bleeding Gums |
| Difficulty opening or closing | Yes No | Bad Taste | Bad Breath |
| Difficulty chewing | Yes No | Food Catching | Tooth Pain |
| History of trauma to jaw or face | Yes No | Clenching | Grinding |
| Diagnosis of TMJ/TMD | Yes No | Other: _____ | |

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**To the best of my knowledge, the information above is complete and accurate.**

Signature: _____ Date_____