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FAMILY DENTAL

Personal Information

Patient Name: _____ Date of Birth: _____
___ Male ___ Female ___ Married ___ Single ___ Child S.S. # _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone (home): _____ (work): _____
(cell): _____ Email Address: _____
Where do you prefer to receive calls? ___ Home ___ Work ___ Cell

Spouse or Responsible Party Information

Responsible Party: _____
Relationship to Patient: _____
Address (if different from patient): _____
City: _____ State: _____ Zip Code: _____
Phone (H): _____ (W): _____ (C): _____
Age: _____ Date of Birth: _____ S.S. # _____
Employer: _____

Primary Dental Insurance Coverage

Name of Insurance Company: _____
Subscriber's Name: _____ Date of Birth: _____
S.S. # _____ Plan Name/Group No.: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____
Name any other family members with whom we may discuss your treatment?
Name: _____ Relationship: _____ Phone: _____

Referral Information

Who may we thank for referring you to our practice?
___ Another patient, friend ___ Yelp ___ Google ___ Facebook
___ Next Door App ___ Preschool ___ Other
Name of person or office referring you to our practice: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have been offered a copy of this office's Notice of Privacy Practices.

_____ _____
(Signature) (Date)

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Name: _____ Date: _____ DOB: _____

Do you have or have you had any of the following diseases or medical problems?

Acid Reflux	___ Y ___ N	Hormone Replacement	___ Y ___ N
Alzheimer's Disease	___ Y ___ N	HIV +/AIDS	___ Y ___ N
Anemia	___ Y ___ N	Heart Murmur	___ Y ___ N
Arthritis	___ Y ___ N	Heart Attack	___ Y ___ N
Artificial Heart Valve	___ Y ___ N	Heart Disease	___ Y ___ N
Artificial Joints	___ Y ___ N	Jaw Pain	___ Y ___ N
Asthma/Hay Fever	___ Y ___ N	Kidney Problems	___ Y ___ N
Blood Disease	___ Y ___ N	Liver Disease/ Jaundice	___ Y ___ N
Blood Transfusion	___ Y ___ N	Mental Illness	___ Y ___ N
Cancer/Chemotherapy	___ Y ___ N	Mitral Valve Prolapse	___ Y ___ N
Chest Pain (Angina)	___ Y ___ N	Pacemaker	___ Y ___ N
Congenital Heart Disorder	___ Y ___ N	Radiation Treatment	___ Y ___ N
Cold Sores	___ Y ___ N	Rheumatic Fever	___ Y ___ N
Diabetes	___ Y ___ N	Severe or Frequent	
Difficulty Breathing	___ Y ___ N	Headaches	___ Y ___ N
Drug/Alcohol Abuse	___ Y ___ N	Shingles	___ Y ___ N
Dry Mouth or		Sinus Problems	___ Y ___ N
Excessive Thirst	___ Y ___ N	Stroke	___ Y ___ N
Epilepsy/Seizures/		Thyroid Disease	___ Y ___ N
Fainting Spells	___ Y ___ N	Tuberculosis (TB)	___ Y ___ N
High/Low Blood Pressure	___ Y ___ N	Ulcers/Colitis	___ Y ___ N
Hepatitis	___ Y ___ N		

Please list any other medical condition you have or have had, NOT listed above:

_____

_____

_____

Physician Name:_____ Date of Last Physical: _____

Are you taking any medications or vitamins? Please list:

_____

_____

_____

Are you or have you ever taken medications containing bisphosphonates (Fosamax, Actonel, Aredia, etc.) ___Y ___N

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Have you been admitted to a hospital or needed emergency care during the past two years? If yes, please explain:

_____

_____

Have you had any surgeries in the past two years? If yes, please explain:

_____

_____

Do you smoke or use Tobacco? ___ Y ___ N
If yes, how much daily? _____

Are you allergic to any of the following?

Aspirin	___ Y ___ N
Penicillin	___ Y ___ N
Codeine	___ Y ___ N
Tetracycline	___ Y ___ N
Dental Anesthetics	___ Y ___ N
Any Metal	___ Y ___ N
Erythromycin	___ Y ___ N
Latex	___ Y ___ N

Any allergies not listed above?

_____

Women: Are you pregnant? ___ Y ___ N Week? _____
Are you nursing? ___ Y ___ N

PATIENT/GUARDIAN SIGNATURE: _____

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Dental Visits: When was your last dental visit? _____ Was your treatment comfortable? Does dental treatment make you nervous? Have you ever seen a dental specialist? Why did you leave your last dentist? _____ _____ Please feel free to include any additional information you would like us to know before treatment: _____ _____	 ___ Y ___ Y ___ Y	 ___ N ___ N ___ N
Oral Hygiene: How many times a day do you brush? How often do you floss per week? How often do you see a dentist? Do your gums ever bleed?	 ___ 2 or more ___ 5 or more days ___ 2x/yr ___ Y	 ___ Less than 2 ___ Less than 5 days ___ < 2x/yr ___ N
Fluoride Exposure: Do you use a fluoride toothpaste? Do you use a fluoride mouth rinse? Do you get professional fluoride treatments?	 ___ Y ___ Y ___ Y	 ___ N ___ N ___ N
Diet: Do you drink soda? Do you snack between meals? Do you have a drink at your desk?	 ___ Y ___ Y ___ Y	 ___ N ___ N ___ N
General Health: Are you taking any medications? Do you suffer from dry mouth? Have you ever received chemo therapy/radiation?	 ___ Y ___ Y ___ Y	 ___ N ___ N ___ N

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Oral Health:		
Do you have any fillings?	___ Y	___ N
Do you have any exposed root surfaces/receding gums?	___ Y	___ N
Did you or do you have braces?	___ Y	___ N
Are your teeth sensitive to hot or cold?	___ Y	___ N
Do you have any food trap areas?	___ Y	___ N
Do you ever experience bad breath?	___ Y	___ N
Cosmetics:		
Are you happy with the color of your teeth?	___ Y	___ N
Are you happy with the length of your teeth?	___ Y	___ N
Are you interested in Botox?	___ Y	___ N