

## Patient Information

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

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

Whom may we thank for referring you to our office? \_\_\_\_\_

PCD \_\_\_\_\_ Sibling IN TX \_\_\_\_\_

## Responsible Party Information

Name \_\_\_\_\_  
Last First Middle Marital Status

Residence \_\_\_\_\_  
Street City State Zip

Mailing Address \_\_\_\_\_  
Street City State Zip

How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

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 Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

## Insurance Information

Insured's Name \_\_\_\_\_ Insured's Soc. Sec. # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Do you have dual coverage? Yes  No  If yes:

Insured's Name \_\_\_\_\_ Insured's Soc. Sec. # \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insured's Employer \_\_\_\_\_

## Emergency Information

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone \_\_\_\_\_

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

Signature (Parent's signature if minor) \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_

# MEDICAL / DENTAL HISTORY

Birth date: \_\_\_\_\_

Name of former dentist: \_\_\_\_\_ Date of last dental examination: \_\_\_\_\_

Physician's name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

When did you last consult a physician? \_\_\_\_\_ Reason: \_\_\_\_\_

Have you been a patient in a hospital in the past 5 years:  Yes  No Reason \_\_\_\_\_

Have you had any serious illnesses or operations?  Yes  No Explain: \_\_\_\_\_

Ethnic Background: \_\_\_\_\_ Caucasian \_\_\_\_\_ Hispanic \_\_\_\_\_ Asian \_\_\_\_\_ AfroAmerican \_\_\_\_\_ Other: \_\_\_\_\_

Do you have, or have you had, any of the following (Please check and describe fully under remarks):

- |                                | YES                      | NO                       |                                   | YES                      | NO                       |                                      | YES                      | NO                       |
|--------------------------------|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|
| 1. Heart Disease .....         | <input type="checkbox"/> | <input type="checkbox"/> | 11. Psychiatric Treatment .....   | <input type="checkbox"/> | <input type="checkbox"/> | 21. Allergies .....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. High Blood Pressure .....   | <input type="checkbox"/> | <input type="checkbox"/> | 12. Arthritis .....               | <input type="checkbox"/> | <input type="checkbox"/> | a. Penicillin .....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Blood disorder-anemia ..... | <input type="checkbox"/> | <input type="checkbox"/> | 13. Tumor History .....           | <input type="checkbox"/> | <input type="checkbox"/> | b. Other Antibiotics .....           | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Rheumatic Fever .....       | <input type="checkbox"/> | <input type="checkbox"/> | 14. Venereal Disease .....        | <input type="checkbox"/> | <input type="checkbox"/> | c. Codeine, Aspirin .....            | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Heart Murmur .....          | <input type="checkbox"/> | <input type="checkbox"/> | 15. Sinus Trouble .....           | <input type="checkbox"/> | <input type="checkbox"/> | d. Local Anesthetic, Novocaine ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Thyroid Disease .....       | <input type="checkbox"/> | <input type="checkbox"/> | 16. Ulcers .....                  | <input type="checkbox"/> | <input type="checkbox"/> | e. Others .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Diabetes .....              | <input type="checkbox"/> | <input type="checkbox"/> | 17. Radiation Treatment .....     | <input type="checkbox"/> | <input type="checkbox"/> | 22. Asthma .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Stroke .....                | <input type="checkbox"/> | <input type="checkbox"/> | 18. Liver or Kidney Disease ..... | <input type="checkbox"/> | <input type="checkbox"/> | 23. Tuberculosis, Emphysema .....    | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Epilepsy .....              | <input type="checkbox"/> | <input type="checkbox"/> | 19. Hepatitis, Jaundice .....     | <input type="checkbox"/> | <input type="checkbox"/> | 24. Do you smoke? .....              | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Fainting .....             | <input type="checkbox"/> | <input type="checkbox"/> | 20. Excessive Bleeding .....      | <input type="checkbox"/> | <input type="checkbox"/> | 25. Are you pregnant? .....          | <input type="checkbox"/> | <input type="checkbox"/> |

26. Herpes .....  YES  NO 29. Do you wear a pacemaker? .....  YES  NO

27. Have you tested positive for AIDS virus? .....  YES  NO 30. Should you be taking any medications? .....  YES  NO

28. Are you taking any medicines, drugs or pills? .....  YES  NO 31. Do you wear contact lenses? .....  YES  NO

32. Have you experienced any unfavorable reaction to previous dental treatment? Explain below .....  YES  NO

33. Do you have any disease, condition or problem not listed above that you think I should know about? Explain below .....  YES  NO

34. Other notes: \_\_\_\_\_

35. Do you use alcohol or drugs recreationally? \_\_\_\_\_

Changes in Medical or Dental Health, (please use above code number (s) to show any change).

_____ DATE	_____ PATIENT'S SIGNATURE	# <input type="checkbox"/>	_____ DATE	_____ PATIENT'S SIGNATURE	# <input type="checkbox"/>
_____ DATE	_____ PATIENT'S SIGNATURE	# <input type="checkbox"/>	_____ DATE	_____ PATIENT'S SIGNATURE	# <input type="checkbox"/>