

GENERAL INFORMATION

First Name Last Name MI Preferred

Street Address

City State Zip

Home Phone Cell Phone E-mail

Preferred Contact Method

Cell Phone E-Mail Text Home Phone

Date of Birth Social Security Number Gender
 Male Female

Occupation/Employer Marital Status
Married Single
Divorced Widowed

Language, Race, Ethnicity Emergency Contact Person and Phone

INSURANCE INFORMATION

Dental Insurance Dental Insurance Member Name

Dental Insurance Member ID# Dental Insurance Member Date of Birth

Primary Medical Insurance Primary Member Name

Insurance ID#

Insurance Policy#/Group ID#

Primary Member Date of Birth

Primary Member Social Security Number

Primary Member Employer

Relationship to Primary Member

Spouse Child
Other

Secondary Medical Insurance

Secondary Medical Insurance Member Name

Secondary Medical Insurance ID#

Secondary Medical Insurance Policy #/
Group ID#

Secondary Medical Insurance Member Date of Birth

Secondary Medical Insurance Member Social Security Number

Your Relationship to Secondary Medical Insurance Member

Spouse Child
Other

DENTAL INFORMATION

Have you ever had orthodontic (braces) treatment?

Yes No DK

Are your teeth sensitive to cold, hot, sweets or pressure?

Yes No DK

Do your gums bleed when you brush or floss?

Yes No DK

Is your mouth dry?

Yes No DK

Is your home water supply fluoridated?

Yes No DK

Do you have earaches or neck pains?

Yes No DK

Have you had any periodontal (gum) treatments?

Yes No DK

Do you drink bottled or filtered water?

Yes No DK

Have you ever had orthodontic (braces) treatment?

Yes No DK

Does food or floss catch between your teeth?

Yes No DK

Do you have any clicking, popping or discomfort in the jaw?

Yes No DK

Have you ever had a serious injury to your head or mouth?

Yes No DK

Do you brux or grind your teeth?

Yes No DK

Date of your last dental exam:

Date of last dental x-rays:

Do you have sores or ulcers in your mouth?

Yes No DK

Do you participate in active recreational activities?

Yes No DK

Do you wear dentures or partials?

Yes No DK

Are you currently experiencing dental pain or discomfort?

Yes No DK

How do you feel about your smile?

What was done at that time?

What is the reason for your dental visit today?

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Select all that apply.

AIDS/HIV

Yes

No

Family

Allergies

Yes

No

Family

Arthritis

Yes

No

Family

Asthma

Yes

No

Family

Blood/Lymph Disorder

Yes

No

Family

Cancer

Yes

No

Family

Ears, Nose, Throat Conditions

Yes

No

Family

Diabetes

Yes

No

Family

Gastrointestinal Conditions	Heart Disease	High Blood Pressure	High Cholesterol
Yes	Yes	Yes	Yes
No	No	No	No
Family	Family	Family	Family

Kidney Disease	Lupus	Neurological Conditions	Psychiatric Disorder
Yes	Yes	Yes	Yes
No	No	No	No
Family	Family	Family	Family

Seizures	Skin Conditions	Stroke	Thyroid Dysfunction
Yes	Yes	Yes	Yes
No	No	No	No
Family	Family	Family	Family

Current Medications
(prescription and over-the-counter and dosage)

Medication Drug Allergies

Are you pregnant or nursing?

Height

Weight

Do you smoke?

Have you ever smoked?