Welcome to Professional Dental

Patient Information
(Confidential)

Name: ______________________ What do you prefer to be called? ______________

Birthdate: _____ / _____ / _____ Age: ____ SS # ______________ Sex: M F

Mailing Address: ______________________ City: ________ State: ______ Zip: _____

Home Phone : ____________ Work Phone: ____________ Cell Phone: ____________

Email Address: ______________________ Employer: ______________________

Spouse's Name: ______________ Do you have children? ☐ No ☐ Yes How Many? ________

Status : ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Person to contact in case of emergency: ____________________ Phone: ______________

How did you hear about us? (Check all that apply) ☐ Brochure / Flyer ☐ Yellow Pages ☐ Newspaper

☐ Sign ☐ Family / Friend Name: ____________________ ☐ Other ____________

Responsible Party

☐ **Check if same as above**

Name of Person Responsible for Account ______________________ Relationship to Patient ________

Mailing Address ______________________ City ____________ State ____ Zip ______

Home Phone ____________________ Work Phone ______________ Date of Birth ________

Employer ______________________ Social Security # ______________________

For your convenience, we offer the following methods of payment; please check the option you prefer:

☐ Cash ☐ Personal Check ☐ Credit Card (Visa, MasterCard, American Express, Discover)

☐ I wish to discuss the office payment policy

Insurance Information

Insurance Co. Name: ____________________ Group # ________ Insurance Phone #: __________

Insurance Address: ______________________________ Employer: ______________

Name of Insured: ______________________________ Date of Birth: ______________

Social Security #: ______________ Relationship to Patient: ____________ Work Phone: __________

Additional Insurance

Do you have additional insurance? ☐ No ☐ Yes If yes, please complete the following:

Insurance Co. Name: ______________________ Group # __________ Insurance Phone #:__________

Insurance Address: ______________________________________ Employer: ______________

Name of Insured: ____________________________________ Date of Birth: ______________

Social Security #: ______________ Relationship to Patient: __________ Work Phone: __________

Medical History

Physician: __________________ Office Phone: ____________ Date of last visit: ____________

Are you under medical treatment now? ☐ No ☐ Yes If yes, please explain: ______________________

Have you been hospitalized for any surgical operations or serious illness within the last 5 years? ☐ Yes ☐ No

If yes, please explain: ____

Are you taking medications? ☐ Yes ☐ No If yes, please list: ________________________________

Have you ever taken Phen Fen? ☐ Yes ☐ No Do you use controlled substances? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No If yes, how used & how long? ______________________________

Are you allergic to or had reactions to any of the following?

Yes	No	
		Local Anesthetics (eg. Novocaine)
		Penicillin or any other Antibiotics
		Latex Rubber
		Any Metals (eg. Nickel, Mercury, etc.)

Yes	No	
		Codeine
		Other
		Please explain: ______________________

____

Do you now have or have you ever had any of the following?

Yes	No	
		High Blood Pressure
		Low Blood Pressure
		Diabetes
		Heart Attack
		Heart Murmur
		Swollen Ankles
		Mitral Valve Prolapse
		Fainting
		Other Please explain:

Yes	No	
		Seizures
		Asthma
		Anemia
		AIDS / HIV
		Thyroid Problem
		Stroke
		Tuberculosis
		Epilepsy / Convulsion

Yes	No	
		Liver Disease
		Heart Disease
		Cardiac Pacemaker
		Respiratory Problems
		Rheumatic Fever
		Leukemia
		Kidney Disease
		Cancer

Yes	No	
		Emphysema
		Joint Replacement
		Sexually Transmitted Disease
		Stomach Ulcers/Troubles
		Glaucoma
		Hay Fever / Allergies
		Radiation Therapy
		Hepatitis/Jaundice

Women Only

Are you pregnant or think you might be pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you taking contraceptives? Yes No

Dental History

Previous dentist and location:

____

Times a day you brush ________ Times a week you floss _________ How would you rate your smile?

(1-10) __________

Do you require antibiotic pre-medication? ☐ Yes ☐ No

Do you now have any of the following?

☐ Red, swollen bleeding gums
☐ Pain in teeth

☐ Clicking or pain in joint
☐ Clenching or grinding of teeth

- [ ] Teeth sensitive to hot cold or sweets
- [ ] Broken or chipped teeth or fillings
- [ ] Sores or lumps in or near your mouth
- [ ] Lost or broken fillings
- [ ] Frequent Headaches
- [ ] Bad Breath
- [ ] Snoring
- [ ] Anxiety that has kept you from seeking dental treatment

Authorization & Release

Signature of Patient (or parent if minor) X_________________________

Date: _______