



Welcome to Professional Dental

Patient Information
(Confidential)

Name: _____ What do you prefer to be called? _____

Birth date: ____/____/____ 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 / Flier 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, Master Card, 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		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics (eg. Novocaine)	<input type="checkbox"/>	<input type="checkbox"/>	Codeine
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or any other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>	Please explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Any Metals (eg. Nickel, Mercury, etc.)			

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

Yes	No		Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	AIDS / HIV	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers/Troubles
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / Convulsion	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Other	Please explain: _____								

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

Times a day you brush _____ Times a week you floss _____
 Using 10 as the highest rating and 1 as the lowest, how would you rate your smile? _____
 Do you require antibiotic pre-medication? Yes No

Do you currently have any of the following?

<input type="checkbox"/>	Red, swollen bleeding gums	<input type="checkbox"/>	Clicking or pain in joint
<input type="checkbox"/>	Pain in teeth	<input type="checkbox"/>	Clenching or grinding of teeth
<input type="checkbox"/>	Teeth sensitive to hot cold or sweets	<input type="checkbox"/>	Frequent Headaches
<input type="checkbox"/>	Broken or chipped teeth or fillings	<input type="checkbox"/>	Bad Breath
<input type="checkbox"/>	Sores or lumps in or near your mouth	<input type="checkbox"/>	Snoring
<input type="checkbox"/>	Lost or broken fillings	<input type="checkbox"/>	Anxiety that has kept you from seeking dental treatment

Authorization & Release

Signature of Patient (or parent if minor) _____
 Date: _____