CHILD PATIENT

Name

Nickname

Birth Date / / Age

Social Security No.

Address

City, State, Zip

Telephone Number

Responsible Party

Relation to Child

Parent or legal guardian please complete the information to the right.

ADULT PATIENT

Name

Nickname

Birth Date / / Age

Social Security No.

Address

City, State, Zip

D.L. #

Phone: (Home)

(Work)

Email

Employed By

How Long

Present Position

Are you: Single
Married
Divorced
Widowed
Other

Name of Partner

Employed By

How Long

Present Position

Employer Phone

Who May We Thank For Referring You Here

In Case of Emergency, Who Do We Contact
Address
Phone

Name Of Dental Insurance

Note: Dental Insurance typically requires payment of deductable & co-pay at the time of service.

Date of last dental visit ___/____/____

What was Done?_____
_____

Purpose of this visit?_____
_____

Are you in discomfort at this time?
_____

Area of concern? _____

Are you interested in improving your smile? _____

Have you ever had periodontal treatment? _____

Have you ever had orthodontic treatment? _____

Source of drinking water? _____
_____

Name of Physician _____
Phone _____

Current weight _____

Could you be pregnant? _____
If so, your due date is? _____

What medications are you taking?
_____
_____
_____

Known Allergies: _____
_____
_____
_____

Have you ever been admitted into the Hospital & for what? _____
_____
_____
_____

- ❑ Steroids in last 2 years
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Diabetes
- ❑ Hepatitis/Jaundice
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Venereal Disease
- ❑ Special Diet
- ❑ Tobacco Use
- ❑ Psychiatric Care
- ❑ Presently Taking Medicine
- ❑ Respiratory Disease
- ❑ Any Heart Problems
- ❑ Circulatory Problems
- ❑ Excessive Bleeding/Blood Disorder
- ❑ Rheumatic Fever
- ❑ AIDS/HIV
- ❑ Nervous Problems
- ❑ Allergies to anesthetics / medicine
- ❑ Low Blood Pressure
- ❑ High Blood Pressure
- ❑ Artificial Joints/Heart Valve
- ❑ Liver Disease
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Chronic Diarrhea
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Seizures
- ❑ Chemo/Radiation
- ❑ Recent Weight Loss
- ❑ Transfusions
- ❑ Ever Hospitalized
- ❑ Other

Health and personal information has been provided to the best of my ability. I will provide information on any changes in personal or health status as they occur. I understand I am ultimately responsible for all fees incurred. I understand there is a fee for all missed appointments, also any balance over 30 days is subject to a late payment charge.

Signature _____ Date ____/____/____ Dentist _____