

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

- Yes
- No
- Family

Heart Disease

- Yes
- No
- Family

High Blood
Pressure

- Yes
- No
- Family

High
Cholesterol

- Yes
- No
- Family

Kidney Disease

- Yes
- No
- Family

Lupus

- Yes
- No
- Family

Neurological
Conditions

- Yes
- No
- Family

Psychiatric
Disorder

- Yes
- No
- Family

Seizures

- Yes
- No
- Family

Skin Conditions

- Yes
- No
- Family

Stroke

- Yes
- No
- Family

Thyroid
Dysfunction

- Yes
- No
- 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?