Today's Date:___________________________

Name:_______________________________________ I prefer to be called:__________________________Gender: _____________

Home Address: ____ Birthdate: ______________

Cell #: _____________________ Home #: _______________________Work #: _______________________ Ext. __________

Email address:___________________________________ **Preferred appt reminder method: ( )Email ( )Phone (home /cell)**

() Single () Married () Divorced () Widowed () Separated Spouse Name: ____

Employer**:** ____ Occupation: _____________________________________

Employer's Address: ____

Whom may we thank for referring you? _______________________________________

Other family members seen by us: ____

Person Responsible for Account

Name: _______________________________________ Relationship to patient: ___________________________________

Employer: ________________________ Date of Birth: __________________________ SSN ________________________

Billing Address: ____Cell # _______________________

Do you have orthodontic insurance? Y / N

Name of Policy Holder: _____________________________ Date of Birth: _________________ Relation to Patient__________

Primary Insurance Company: _______________________ ID # __________________________ Group #______________

ClaimsMailingAddress:____

Secondary Company: ____________________________ ID #: ___________________________ Group #_____________

Claims Mailing Address: ____

Dental History

Name of General Dentist _____________________________________
Address____ **Phone**___________________________________
Date of last dental visit_________________________________
Why have you come to the dentist today?____
Your current dental health is: Good Fair Poor
Are you currently in pain? **Y / N**
Has there been trauma to teeth or jaws? **Y / N**
Date and description of trauma ____
Have you been informed of any missing or extra permanent teeth? **Y / N**
If yes, which one(s) ____
Do you have mobility in your teeth? **Y / N**
Have you experienced problems associated with any previous dental work? ____
Are your teeth sensitive to heat, cold, or anything else? ____
Do you still have wisdom teeth? **Y / N** If yes, why? ____
Do you now or have your ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? **Y / N**
Do your gums ever bleed? **Y / N** Ever Itch? **Y / N**
Have you ever had periodontal disease? **Y / N**
Do you floss daily? **Y / N** Brush daily? **Y / N** Type of bristles on your toothbrush? ____________
How long do you use a toothbrush before replacing it? _________________
Do you use anything in addition to your brush and floss? **Y / N** If yes, what? ____
Would you like fresher breath? **Y / N** Whiter teeth? **Y / N**
Are you happy with the way your smile looks? Y / N If not, what would you change? ____________________________

Medical History

Patient Name: ___________________________________

Do you have a personal physician? **Y** **N** Physician's Name: ____
Address: ____Phone #: ____________________Date of last visit: _________________
Your current physical health is: Good Fair Poor Are you currently under the care of a physician? **Y** **N**
Please explain: ____

Are you allergic to any of the following?

Aspirin Latex Dental Anesthetics Sulfa Drugs
Barbiturates Penicillin Codeine Sedatives
Erythromycin Tetracycline Jewelry/Metals/Nickel Other ____

Please list additional drugs/materials that may cause allergic reactions: ____
Do you smoke or use tobacco in any other form? **Y** **N**

For Women: Are you taking birth control pills? Yes No
Are you pregnant? Unsure Yes No Week #: ______ Are you nursing? Yes No

Are you taking any of the following?

Acetaminophen Blood Thinners Insulin/Diabetes Drugs Thyroid Medicine
Antibiotics Blood Pressure Medicine Nitroglycerin Tranquilizers
Antihistamines Cold Remedies Recreational Drugs Have you ever taken
Aspirin Digitalis/Heart Meds Steroids/Cortisone Phen-Fen? Also known as Redux or Pondimin.
Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? **Y** **N**
If yes, please list each one: ____

Do you or have you experienced the following?

Abnormal Bleeding Fainting Spells Mitral Valve Prolapse
Alcohol Abuse Fever Blisters Pacemaker
Anemia Glaucoma Persistent Cough
Arthritis Hay Fever Psychiatric Problems
Artificial Bones/Joints Headaches Radiation Treatment
Artificial Valves Heart Attack Rheumatic Fever
Asthma Heart Murmur Scarlet Fever
Blood Transfusion Heart Surgery Seizures
Cancer Hemophilia Shingles
Chemotherapy Hepatitis Sickle Cell Disease
Chicken Pox Herpes Sinus Problems
Colitis High Blood Pressure Steroid Therapy
Congenital Heart Defect HIV+/AIDS Stroke
Diabetes Hospitalized for Any Reason Thyroid Problems
Difficulty Breathing Kidney Problems Tonsillitis
Drug Abuse Liver Disease Tuberculosis (TB)
Emphysema Low Blood Pressure Ulcers
Epilepsy Lupus Venereal Disease

Please list any serious medical condition(s) that you have experienced: ____

Authorization

I affirm that the information I have give is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Signature____**Date**________________