

CONFIDENTIAL PERSONAL INFORMATION

DATE \_\_\_\_\_

**THIS PERSONAL INFORMATION HELPS US GIVE YOU THE MOST CONSIDERATION OF YOUR TIME AND FEELINGS. ALL INFORMATION IS OF COURSE CONFIDENTIAL.**

PATIENT NAME: \_\_\_\_\_ MALE: \_\_\_\_\_ FEMALE: \_\_\_\_\_

WHAT DO YOU PREFER TO BE CALLED: \_\_\_\_\_

MARRIED: \_\_\_\_\_ SINGLE: \_\_\_\_\_ DIVORCED: \_\_\_\_\_ WIDOWED: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_

CELL PHONE#: \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

DRIVER'S LICENSE #: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ SPOUSE'S NAME: \_\_\_\_\_

SPOUSE'S PLACE OF EMPLOYMENT: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

SPOUSE'S BUSINESS PHONE: \_\_\_\_\_ SPOUSE'S BIRTHDATE: \_\_\_\_\_

FINANCIAL INFORMATION

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ CURRENT STREET ADDRESS: \_\_\_\_\_

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_

HOME PHONE#: \_\_\_\_\_ WORK PHONE#: \_\_\_\_\_

PRIMARY DENTAL INSURANCE INFORMATION

INSURED PERSON'S FULL NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ PLACE OF EMPLOYMENT: \_\_\_\_\_

ARE YOU HOURLY \_\_\_\_\_ OR SALARIED? \_\_\_\_\_

INSURANCE COMPANY NAME: \_\_\_\_\_ GROUP #: \_\_\_\_\_

DO YOU HAVE OTHER DENTAL COVERAGE? \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES, CONTINUE

SECONDARY DENTAL INSURANCE INFORMATION

INSURED PERSON'S FULL NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ PLACE OF EMPLOYMENT: \_\_\_\_\_

ARE YOU HOURLY \_\_\_\_\_ OR SALARIED? \_\_\_\_\_

INSURANCE COMPANY NAME: \_\_\_\_\_ GROUP#: \_\_\_\_\_

**DENTAL INFORMATION**

**HOW LONG HAS IT BEEN SINCE YOU HAVE SEEN A DENTIST?** \_\_\_\_\_

**ARE YOU HAVING PROBLEMS NOW?** \_\_\_\_\_ **IF SO, WHAT** \_\_\_\_\_

**NAME OF PREVIOUS DENTIST** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

**DO YOU HAVE ANY OF THE FOLLOWING PROBLEMS: (PLEASE MARK ANY THAT APPLY)**

**CLICKING, POPPING OR DISCOMFORT IN THE JAW?** \_\_\_\_\_

**RECEEDING, RED, SWOLLEN, OR BLEEDING GUMS?** \_\_\_\_\_

**SENSITIVE TEETH OR GUMS?** \_\_\_\_\_

**SORES OR BLISTERS IN OR AROUND THE MOUTH?** \_\_\_\_\_

**LOOSE OR BROKEN FILLINGS OR TEETH?** \_\_\_\_\_

**CLENCHING OR GRINDING OF TEETH?** \_\_\_\_\_

**RINGING IN THE EARS?** \_\_\_\_\_

**SORENESS IN THE JOINT MUSCLES?** \_\_\_\_\_

**LIMITATIONS IN OPENING YOUR MOUTH?** \_\_\_\_\_

**HEADACHES?** \_\_\_\_\_

**STAINED/DISCOLORED TEETH?** \_\_\_\_\_

**BAD BREATH?** \_\_\_\_\_

**DRY MOUTH?** \_\_\_\_\_

**BURNING TONGUE?** \_\_\_\_\_

**ARE THERE ANY OTHER CONCERNS OR QUESTIONS THAT YOU HAVE THAT WE HAVE NOT COVERED ABOVE?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**WHO RECOMMENDED OUR OFFICE?** \_\_\_\_\_

**MEDICAL HISTORY**

**ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?**

- |   |  |
|---|--|
| <input type="checkbox"/> PAIN MEDICATIONS (INCLUDING ASPIRIN) | <input type="checkbox"/> MUSCLE RELAXERS |
| <input type="checkbox"/> STIMULANTS                           | <input type="checkbox"/> BLOOD THINNERS  |
| <input type="checkbox"/> TRANQUILIZERS                        | <input type="checkbox"/> INSULIN         |
| <input type="checkbox"/> OTHERS                               |  |

**DO YOU OR HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR CONDITIONS?(CHECK ANY THAT APPLY)**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> HEART ATTACK/STROKE     | <input type="checkbox"/> KIDNEY PROBLEMS      | <input type="checkbox"/> CHEMOTHERAPY               |
| <input type="checkbox"/> HEART SURGERY/PACEMAKER | <input type="checkbox"/> LIVER PROBLEMS       | <input type="checkbox"/> SHINGLES                   |
| <input type="checkbox"/> HEART MURMUR            | <input type="checkbox"/> RESPIRATORY PROBLEMS | <input type="checkbox"/> HEPATITIS                  |
| <input type="checkbox"/> RHEUMATIC FEVER         | <input type="checkbox"/> SINUS PROBLEMS       | <input type="checkbox"/> HIV+/AIDS/ARC              |
| <input type="checkbox"/> MITRAL VALVE PROLAPSE   | <input type="checkbox"/> STOMACH PROBLEMS     | <input type="checkbox"/> ARTHRITIS/RHEUMATISM       |
| <input type="checkbox"/> ARTIFICIAL VALVES       | <input type="checkbox"/> PSYCHIATRIC PROBLEMS | <input type="checkbox"/> ARTIFICIAL BONES/JOINTS    |
| <input type="checkbox"/> HEART DISEASE           | <input type="checkbox"/> VENEREAL DISEASES    | <input type="checkbox"/> IMPLANTS                   |
| <input type="checkbox"/> CONGENITAL HEART DEFECT | <input type="checkbox"/> ALCOHOL/DRUG ABUSE   | <input type="checkbox"/> EMPHYSEMA                  |
| <input type="checkbox"/> CHEST PAINS             | <input type="checkbox"/> TUBERCULOSIS TB      | <input type="checkbox"/> FAINTING/SEIZURES/EPILEPSY |
| <input type="checkbox"/> SCARLET FEVER           | <input type="checkbox"/> JAW PROBLEMS         | <input type="checkbox"/> SEVERE/FREQUENT HEADACHES  |
| <input type="checkbox"/> ASTHMA                  | <input type="checkbox"/> DIFFICULTY BREATHING | <input type="checkbox"/> FREQUENT NECK PAIN         |
| <input type="checkbox"/> LEUKEMIA                | <input type="checkbox"/> ANEMIA               | <input type="checkbox"/> DIABETES/HYPOGLYCEMIA      |
| <input type="checkbox"/> BACK PROBLEMS           | <input type="checkbox"/> BLEEDING PROBLEMS    | <input type="checkbox"/> HIGH/LOW BLOOD PRESSURE    |
| <input type="checkbox"/> THYROID DISEASE         | <input type="checkbox"/> CANCER/TUMORS        | <input type="checkbox"/> RADIATION TREATMENT        |
| <input type="checkbox"/> GLAUCOMA                | <input type="checkbox"/> BLOOD TRANSFUSION    |   |

**ARE YOU ALLERGIC TO OR HAVE YOU REACTED TO ANY OF THE FOLLOWING?**

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> ASPIRIN                        | <input type="checkbox"/> LOCAL ANESTHETIC | <input type="checkbox"/> ERYTHROMYCIN |
| <input type="checkbox"/> LATEX (BALLOONS, GLOVES, ETC.) | <input type="checkbox"/> CODEINE          | <input type="checkbox"/> PENICILLIN   |

OTHERS, \_\_\_\_\_  
\_\_\_\_\_

IS THERE ANY FAMILY HISTORY OF:       CANCER       PERIODONTAL DISEASE

FAMILY PHYSICIAN \_\_\_\_\_ PHONE #: \_\_\_\_\_

NAME OF CLOSEST RELATIVE \_\_\_\_\_ PHONE#: \_\_\_\_\_

**I AUTHORIZE THE STAFF TO PERFORM ANY NECESSARY SERVICES NEEDED DURING DIAGNOSIS AND TREATMENT. I ALSO AUTHORIZE THE PROVIDER TO RELEASE ANY INFORMATION REQUIRED TO PROCESS INSURANCE CLAIMS.**

**I UNDERSTAND THE ABOVE INFORMATION AND GUARANTEE THIS FORM WAS COMPLETED CORRECTLY TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES TO THE INFORMATION THAT I HAVE PROVIDED.**

**I ALSO UNDERSTAND THAT MY DENTAL INSURANCE IS A CONTRACT BETWEEN ME AND THE INSURANCE CARRIER, AND NOT BETWEEN THE INSURANCE CARRIER AND THE DOCTOR, AND THAT I AM RESPONSIBLE FOR ALL DENTAL FEES. THESE FEES ARE DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED UNLESS PRIOR FINANCIAL ARRANGEMENTS ARE MADE. I ALSO ASSIGN ALL INSURANCE BENEFITS TO THE DOCTOR.**

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

