LAST NAME ______ **FIRST NAME** ______ **MI** ____ **Age** ____

Address: ______ City: ______ State: ______ Zip: ______

Birthdate: ___/___/___ Soc. Sec. #: ___-___-___ Home Phone: ___-___-___ ☐ Single ☐ Married ☐ Other ______

Work Phone: ___-___-___ Cell Phone: ___-___-___ ☐ Employed ☐ Student, if student where? ______

Employer: ______ Present position: ______ How long held? ______

Insurance Co. ______ Policy: ______ Group# ______ Local: ______

Do you live with both parents? ☐ Yes ☐ No ☐ Mother? ☐ Father? ☐ Guardian? Who is responsible for payment? ______

Father (or male guardian) Complete Name: ______ DOB: ___/___/___ SS# ___-___-___

Home Address (if different from patient) ______ Zip ______ Home Phone: ___-___-___ Cell Phone: ___-___-___

☐ Employed ☐ Homemaker ☐ Retired ☐ Other ______ ☐ Student, If student where? ______ Local#: ______

Employed by: ______ Address/City: ______ State: ______ Zip: ______

Present position: ______ How long held? ______ Work phone: ___-___-___

Dental insurance company: ______ Group#: ______ Policy#: ______

Mother (or female guardian) Complete Name: ______ DOB: ___/___/___ SS# ___-___-___

Home Address (if different from patient) ______ Zip ______ Home Phone: ___-___-___ Cell Phone: ___-___-___

☐ Employed ☐ Homemaker ☐ Retired ☐ Other ______ ☐ Student, If student where? ______ Local#: ______

Employed by: ______ Address/City: ______ State: ______ Zip: ______

Present position: ______ How long held? ______ Work phone: ___-___-___

Dental insurance company: ______ Group#: ______ Policy#: ______

Method of payment for dental care: ☐ Payment in full at each appointment. ☐ Insurance or prepaid program.

I first learned about this dental office from: ☐ Phone Book/specify: ______ ☐ Website ☐ School ☐ Work

Referred by: ☐ Another patient, friend ☐ Another patient, relative ☐ Dental office doctor or staff member. ☐ Other ______

Name of person who referred us: ______ Best phone number to call about appointments: ______

DENTAL HISTORY Is this your first visit to the Dentist? ☐ Yes ☐ No Reason for todays visit ______

Have you been having any specific problems? ☐ Yes ☐ No Describe: ______

Last dental visit: ______ Purpose: ______ Date of last dental x-rays: ______ Last complete exam: ______

Has fear of discomfort kept you from regular visits? ☐ Yes ☐ No ☐ How do you describe your dental health? ☐ Good ☐ Fair ☐ Poor

Do you think you have active dental disease: Decay? ☐ Yes ☐ No Gum Disease? ☐ Yes ☐ No

Home Care: Brush? ☐ Yes ☐ No Floss? ☐ Yes ☐ No ☐ Electric toothbrush ☐ Yes ☐ No Brand: ______

Do your gums ever bleed? ☐ Yes ☐ No How often? ______ Are you troubled with bad breath? ☐ Yes ☐ No Dry Mouth? ☐ Yes ☐ No

How do you feel about ever losing your teeth? ______ Existing dental prosthetics? ☐ Yes ☐ No Year placed? ______

Have you had any unusual effects from previous dental treatment? ☐ Yes ☐ No Describe ______

MEDICAL HISTORY (Confidential, Repeated every five years.) Medical doctor's name: ______

Last physical exam: ______ Do you have any medical problems? ☐ Yes ☐ No Describe ______ Sex: ☐ M ☐ F

(Women) Are you pregnant? ☐ Yes ☐ No Expected delivery date: ______

Are you under a doctor's care now? ☐ Yes ☐ No If so, for what reason?: ______

Are you taking any medication, pills or drugs? ☐ Yes ☐ No Please list: ______

HAVE YOU EVER HAD ANY OF THE FOLLOWING? INDICATE YES WITH CHECK MARK (√).

☐ HIV/AIDS	☐ Excessive bleeding	☐ Kidney disease	☐ Psychiatric care	☐ Typhoid fever	B/P
☐ Any heart problems	☐ Prolonged bleeding	☐ Kidney dialysis	☐ Radiation treatments	☐ Ulcer	
☐ Anemia	☐ Fainting spells	☐ Low blood pressure	☐ Rheumatic fever	☐ Venereal disease	
☐ Arthritis	☐ Heart murmur	☐ Malignancies	☐ Scarlet fever	☐ Osteoporosis/penia	
☐ Asthma	☐ Hepatitis	☐ Measles	☐ Seizures / convulsions	☐ Latex allergy	
☐ Circulatory problems	☐ Herpes	☐ Mitral valve prolapse	☐ Sinus problems	☐ Allergy to medicine / drugs	
☐ Chicken pox	☐ High blood pressure	☐ Mumps	☐ Stroke	☐ Allergy to foods	
☐ Diabetes	☐ Hospitalization	☐ Nervous problems	☐ Tonsillitis	☐ Allergy to anesthetics	
☐ Epilepsy	☐ Jaundice	☐ Prosthetic valves/joints	☐ Tuberculosis	☐ Other allergies	

List all your allergies here: ______

Have you had any other serious illness? ☐ Yes ☐ No Explain: ______

Previous hospitalization or surgeries? ☐ Yes ☐ No Why: ______

Do you prefer Nitrous Oxide Sedation (tranquilizing air) during your dental treatment? ☐ Yes ☐ No I.V. Sedation? ☐ Yes ☐ No

Have you ever had difficulty with anesthetics? ☐ Yes ☐ No Explain: ______

Do you wish to talk to the doctor about anything not listed? ☐ Yes ☐ No Comments: ______

AUTHORIZATION: PARENT: I acknowledge that the dependant listed above is covered under my dental insurance policy and I am responsible for all fees incurred whether they are covered or not covered by insurance.

Parent Signature ______ Print Name ______ Date ______

AUTHORIZATION: ADULT OR EMANCIPATED MINOR: I hereby authorize the doctor(s) and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge. I acknowledge that I am responsible for all fees incurred whether they are covered or not covered by insurance.

Patient Signature ______ Date ______

Reviewed by Doctor ______ Date ______

I have received a copy of Family Dental Services Notice of Privacy Practices.

Patient Signature ______ Print Name ______ Date ______

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