PATIENT NAME

Last _____ First _____ MI _____

Address: _____ City: _____ State: _____ Zip: _____

Birthdate: _____ Soc. Sec. #: _____ ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

Home Phone: _____ Work Phone: _____ Cell Phone: _____ ☐ Employed ☐ Homemaker ☐ Retired

Employer _____ Present position: _____ How long held? _____

Insurance Co. _____ Effective Date: _____ Group # _____

Spouse / Partner Name: _____ Birthdate: _____ Soc. Sec. #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer _____ Present position: _____ How long held? _____

Insurance Co. _____ Effective Date: _____ Group # _____

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

In case of emergency call: Name: _____ Number: _____

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

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

☐ Other _____ Name of person who referred us: _____

DENTAL HISTORY

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

Last dental visit: _____ Purpose: _____ Last complete exam: _____

Has fear of discomfort kept you from regular visits? ☐ Yes ☐ No

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

Home care: Brush? ☐ Yes ☐ No Floss? ☐ Yes ☐ No Other _____

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

How do you feel about ever losing your teeth? _____

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

Existing dental prosthetics? ☐ Yes ☐ No Year placed? _____

MEDICAL HISTORY (Confidential, Repeated every three years.)

Medical doctor's name: _____ Last physical exam: _____ Current age: _____

Gender: Male___ Female___ Unspecified_____

(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(√).

☐ Any heart problems	☐ Excessive bleeding	☐ Typhoid fever	☐ Malignancies	☐ AIDS	☐ Prosthetic valves/joints
☐ Heart murmur	☐ Anemia	☐ Nervous problems	☐ Radiation treatments	☐ Venereal disease	☐ Latex Allergy
☐ Mitral valve prolapse	☐ Rheumatic fever	☐ Psychiatric care	☐ Asthma	☐ Herpes	☐ Allergy to anesthetics: _____
☐ High blood pressure	☐ Measles	☐ Hospitalization	☐ Stroke	☐ Tuberculosis	☐ Allergy to medicine/drugs: _____
☐ Low blood pressure	☐ Mumps	☐ Diabetes	☐ Ulcer	☐ Sinus problems	
☐ Circulatory problems	☐ Scarlet fever	☐ Arthritis	☐ Hepatitis	☐ Tonsillitis	☐ Other Allergies:

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

Have you been hospitalized in the last two years? ☐ Yes ☐ No Why: _____

Have you ever taken oral or injected medication to prevent osteoporosis? ☐ Yes ☐ No

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

Do you wish to talk to the doctor about any thing not listed? ☐ Yes ☐ No Comments: _____

AUTHORIZATION: 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: _____ B/P _____

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

Patient Signature _____ Date: _____

ADULT PATIENT INFORMATION • DENTAL AND MEDICAL HISTORIES