

Patient Information

Date \_\_\_\_\_  
Mr. Mrs. Ms.

Name \_\_\_\_\_  
FIRST MIDDLE LAST

Nickname \_\_\_\_\_ Names of Children \_\_\_\_\_ Spouse Name \_\_\_\_\_

Birthdate \_\_\_\_\_ Male  Female  Marital Status: S M D W

Address \_\_\_\_\_  
STREET CITY STATE ZIP

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_  
STREET CITY STATE ZIP

Whom may we thank for referring you to our office? \_\_\_\_\_

Dental Insurance Information

Insured's Name \_\_\_\_\_ Insured's Soc. Sec # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

Insurance Company's Address \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Address \_\_\_\_\_

Do you have dual coverage? Yes  No  If yes: \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured SS # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Concerns and Comments

Please list any concerns or comments you feel the doctor should know about you...

Concerns \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Comments \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Emergency Information

Name of nearest relative not living with you \_\_\_\_\_ Phone(s) \_\_\_\_\_

Complete Address \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained.

Responsible Party Signature \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_

# Patient Medical History

Medical Doctor's Name \_\_\_\_\_ Ph (     ) \_\_\_\_\_

	Yes	No
Are you under any medical treatment now? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any major operations? If so, What? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a serious accident involving head injuries? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any adverse response to any drugs including penicillin? .....	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician ever informed you that you have:	<b><u>Name the Medication Taken Below</u></b>	
<b>Yes</b> <b>No</b>		
<input type="checkbox"/> <input type="checkbox"/> A Heart Ailment, Heart Murmur, Mitrovalve Prolapse? .....		
<input type="checkbox"/> <input type="checkbox"/> High or Low Blood Pressure? .....	<b>Yes</b>	<b>No</b>
<input type="checkbox"/> <input type="checkbox"/> Respiratory Disease? .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Diabetes? .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Rheumatic fever? .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Rheumatism or arthritis? .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Tumors or growths? .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Any blood disease? .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Any liver disease? .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Any kidney disease? .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Any stomach or intestinal disease? .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Any venereal disease? .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Yellow jaundice or hepatitis? .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Aids? .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Thyroid Problem? .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Anemia? .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Frequently tired? .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Stroke? .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Tuberculosis? .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Glaucoma? .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Wear contact lenses? .....	<input type="checkbox"/>	<input type="checkbox"/>

Please list ANY other drugs or medication (including birth control, aspirin, tobacco, alcohol, cocaine, etc.) .....

	Yes	No
Do you have night sweats accompanied by weight loss or cough? .....	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to any known materials resulting—in hives, asthma, eczema, etc.? .....	<input type="checkbox"/>	<input type="checkbox"/>
Are you in general good health at this time? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have any wounds healed slowly or presented other complications? .....	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N.....Nursing? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of fainting, seizures, convulsions, epilepsy, or headaches? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had radiation therapy? .....	<input type="checkbox"/>	<input type="checkbox"/>

## Patient Dental History

Do you like your smile? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain in or near your ears? <input type="checkbox"/> Y <input type="checkbox"/> N   Had any orthodontic work? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have clicking or difficulty chewing? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any unhealed injuries or inflamed areas in or around your mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced: any growth or sore spots in your mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>
Snoring? .....	<input type="checkbox"/>	<input type="checkbox"/>
Clenching or grinding teeth? Bite lips or cheeks frequently? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had Novocaine anesthetic? .....	<input type="checkbox"/>	<input type="checkbox"/>
Any reactions or allergic symptoms to novocaine? .....	<input type="checkbox"/>	<input type="checkbox"/>
Any difficult extractions in the past?   Y <input type="checkbox"/> N <input type="checkbox"/> Prolonged Bleeding? ...	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums or Periodontal therapy? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any instruction on correct brushing of teeth & care of your gums? .....	<input type="checkbox"/>	<input type="checkbox"/>

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

*Thanks so much for helping us complete this information!*  
Dr. Clement & Staff