PATIENT INFORMATION ADULT FORM

Today's Date_____

Patient's Name_____ Nickname _____ Date of Birth_____ Sex: M F

Street Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Social Security Number_____ Email_____

Check one: Single_____ Married_____ Divorced_____ Separated_____ Widowed_____

Patient Employed By_____ Work Phone_____

Present Position_____

Name of Spouse_____

Spouse Employed By_____ Work Phone_____

Present Position_____

Preferred Pharmacy _____

Pharmacy Address _____ Pharmacy Phone_____

Person Responsible for Account_____ Phone_____

Address_____ City_____ State_____ Zip_____

****PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT ****

Dental Insurance? Yes_____ No_____

Primary Insurance Company_____ Group Number_____

Insured Name_____ Insured Social Security Number_____

Insured Date of Birth_____ Insured Employer_____

Secondary Insurance Company_____ Group Number_____

Insurance Co. Address_____

Insured Name_____ Insured Social Security Number_____

Insured Date of Birth_____ Insured Employer_____

PLEASE REVIEW INFORMATION ON THIS FORM, MAKE NECESSARY CHANGES THEN SIGN AND DATE BELOW.

Signature	Date	Signature	Date
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL HISTORY Date of last health care examination_____

Reason_____

Have you been hospitalized in the last 5 years? Y N If so, for what_____

Are you pregnant or chance of pregnancy? Yes_____ No_____ If yes, how many months? _____

Do you have OR have you ever had:

	Yes	No		Yes	No
Anemia	____	____	AIDS/HIV	____	____
Diabetes	____	____	Abnormal Bleeding from a cut	____	____
Epilepsy	____	____	Sleep Apnea	____	____
Hepatitis	____	____	Snoring	____	____
Autism	____	____	ADD/ADHD	____	____

Heart Condition ____ ____ If yes, what is the condition _____
Abnormal Blood Pressure ____ ____ If yes, medication taking _____
Artificial Joint Replacements ____ ____ If yes, which joint & when _____
History of Chemo/Radiation ____ ____ If yes, please explain _____
Taking Bone Density Medication ____ ____ If yes, please explain _____

Are you Allergic to:

	Yes	No		Yes	No
Penicillin	____	____	Medication, Soap, Latex,	____	____
Local Anesthetic	____	____	Other, Please List_____		

Do you smoke/vape/chew? _____ ____ If so, How much per day_____

Are you taking any prescription medications or herbal supplements? Yes_____ No_____ If so, Please List_____

Other Physical/Mental Conditions_____

In Case of Emergency, Please Notify_____ Phone_____

Physician's Name_____ Phone_____

Are you currently under a physician's care? Yes_____ No_____ If so, Please Explain_____

DENTAL HISTORY

Date of last dental examination_____
May we request x-rays? Yes_____ No_____ Previous Dentist_____
Have you ever had a bad dental experience? Yes_____ No_____ If so, Please Explain_____
Are you currently having any dental problems? _____
Have you ever had orthodontic treatment (Braces)?_____
Have you ever had periodontal therapy (Gum Treatment)? _____
Do you have full or partial dentures? Yes_____ No_____ If yes, Date placed_____
Do you grind your teeth? Yes_____ No_____ Do you have noise or pain in your jaw (TMJ)? Yes_____ No_____

I understand the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature_____ Date_____

Comments_____

How did you hear about our office? _____