Date_________________ **Confidential Responsible Party Information**

Name____ Marital Status ______________
Last First Middle
Residence____ □ Own □ Rent
Street City State Zip
Mailing Address____ Email____________________________
Street City State Zip
How long at this address______________ Previous address____
(if less than 3 years) Street City State Zip
Home Phone______________________ Work Phone ___________________Cell Phone______________________
Social Security # ___________________ Birthdate________________ Relationship to Patient__________________
Employer____________________________ Occupation______________________ No. of years employed _________
Spouse's Name ____ Relationship to Patient ______________
Last First Middle
Employer ___________________________ Occupation______________________ No. of years employed __________
Social Security # ____________________ Birthdate _______________ Work Phone __________________________

Confidential Patient Information

Patient's Name____
Last First Middle
Address ____
Street City State Zip
Home Phone______________________ Birthdate _________________ Social Security # ________________________
If patient is a minor, give parent's or guardian's name ____
Whom may we thank for referring you to our office? ____

Insurance Information

Policy Holder's Name ____ Social Security # ________________
Insurance Company__________________________ Group # ____________________ Union Local # _______________
Insurance Co. Address____ Insurance Co. Phone ___________________
Policy Holder's Employer ____
Do you have dual coverage? □ No □ Yes If Yes:
Policy Holder's Name ____ Social Security # ________________
Insurance Company__________________________ Group # ____________________ Union Local # _______________
Insurance Co. Address____ Insurance Co. Phone ___________________
Policy Holder's Employer ____

Emergency Information

Name of nearest relative not living with you ____
Complete Address ____
Phone ____ Relationship __________________________________

I understand that where appropriate, credit bureau reports will be obtained.
Signature (Parent's signature if minor) ____
Updates (date & initial) ____

The following information is necessary for proper diagnosis, treatment and records.
Answers to the following question are for our records only and will be considered confidential.
Please place an (X) before any of the following that apply to you.

__ Anemia	__ Pregnancy	__Wear Pacemaker
__ Asthma	Due Date_______	__ Heart Attack
__ Cancer	__ Osteoporosis	__ Heart Surgery
__ Radiation	__ Nervous Disorder	__ Artificial Heart Valve
__ Chemotherapy	__ Depression	__ Heart Murmur
__ High Blood Pressure	__ General Allergies	__ Irregular Heartbeat
__ Low Blood Pressure	__ Penicillin Allergy	__ Mitral Valve Prolapse
__ History of alcohol	__ Sulfa Allergy	__Stroke
Addiction	__ Latex Allergy	__ Kidney Disease
__ History of drug	__ Metal Allergy	__ Liver Disease
Addiction	__ Drug Allergy	__ Hepatitis A B C
__HPV-Human Papilloma	__ Novocaine Allergy	__ AIDS/HIV
Virus	__ Arthritis	__ Hip or Joint Replacement
__ Herpes (cold sores)	__ Diabetes	Date of Replacement _______________
__ Seizures	Type 1__Type 2__	__ Metal or plastic bone replacement
__Migraines/Headaches	__ Rheumatic Fever	__ Blood Transfusion Date ____________

Indicate any illnesses not listed above: ____
Primary Care Physician and Phone Number: ____
Pharmacy: ____
Are you taking any medications now? Please include over the counter medications and vitamins:
____

Are you taking birth control pills?	Yes No
Have you taken drugs for osteoporosis?	Yes No Oral IV
Are you subject to prolonged bleeding?	Yes No
Do you take Coumadin, Plavix, or Pradaxa? (Blood thinners)	Yes No
Do you take aspirin on a regular basis	Yes No
Have you ever had a cardiac work up?	Yes No
Have you ever had a reaction to epinephrine?	Yes No Type of reaction ____________
Have you ever or do you taken antibiotics prior to dental visits?	Yes No ______________________________
Have you ever had collagen injections?	Yes No
Have you ever taken corticosteroids?	Yes No
Have you a history or currently use tobacco?	Yes No

Dental History

Approximate date of your last dental visit ___________ Approximate date of last full set of x-rays______________
Approximate date of last dental cleaning ____________ Do your gums bleed? ______________________________
Have you ever had treatment for gum disease? ____
Do you avoid any part of your mouth when eating or brushing? ____
Does food catch between your teeth? ____
Do you have any pain in your mouth? ____
Do you clench your teeth often? ____
Have you ever had local anesthetic (novocaine)? _________________ Do you prefer it for fillings? _____________
Do you have any teeth missing that were not replaced by bridgework, partial or full dentures, or implants? ______
Have you had orthodontic treatment? ____
Do you have any specific concerns you would like to discuss today? _____________________________________
____
Medical Updates: ____
____