



NAME _____ DATE OF BIRTH _____ MALE FEMALE

STREET _____ CITY _____ STATE _____ ZIP _____

HOME PHONE () _____ CELL PHONE () _____ WORK () _____

Text message reminders? YES NO E-mail reminders? YES NO _____

SOCIAL SECURITY # _____ EMPLOYER/SCHOOL _____

DENTAL INSURANCE CO. _____ (please provide card for photocopy)

If different from above:

INSURED'S NAME _____ DATE OF BIRTH _____ MALE FEMALE

STREET _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY # _____ EMPLOYER/SCHOOL _____

EMERGENCY CONTACT: NAME _____ PHONE () _____

Are you under the care of a physician? (Dr. _____ for: _____) YES NO

Are you taking any medication? Please list: _____

Are you allergic to anything? (Penicillin, Codeine, Acrylic, Metal, Latex, other) _____ YES NO

Have you ever been hospitalized? Please explain: _____ YES NO

Have you ever had a serious injury to your head or neck? _____ YES NO

WOMEN (Circle all that apply) Pregnant - Possibly pregnant - Nursing - Taking oral contraceptives

Are you allergic to any anesthetics? _____ YES NO

Do you wish to talk to the dentist privately about any problems? _____ YES NO

Do you have or have you ever had any of the following? Please Circle Yes or No next to each item

Table with 10 columns of medical conditions and Yes/No options. Conditions include heart trouble, bruise easily, emphysema, kidney problems, fever blisters, etc.

Do you snore? _____ YES NO

Do you feel rested in the morning? Please explain: _____ YES NO

Do you use any tobacco product? _____ YES NO

Do you have a specific dental problem? Please explain: _____ YES NO

Do you like your smile? Please explain: _____ YES NO

Do you have: Sensitive Teeth Bleeding Gums Sore Jaw

Have you had a bad dental experience? Please explain: _____ YES NO

Who can we thank for referring you? _____

I have read everything on this form and have answered correctly to the best of my knowledge.

SIGNATURE _____ DATE _____