Today's Date:__________

Patient's Name | **Birthdate** | **Age** | **Sex: M F**

Home Address	**City**	**State**	**Zip**
Home Phone Number	***Please Circle One:*** Single, Married, Separated, Widow		**Your Soc. Sec. #**
Your Employer	**Occupation**		**Work Phone #**

Are you a full time student?
Yes No *If patient is minor we need:* *Mother's Name & Birthdate* *Father's Name & Birthdate*

Person responsible for account **YOUR Driver's License Number**

Name of spouse (or parent if minor) **YOUR E-mail address** **YOUR cell phone #**

Spouse's (or parent's) employer **Spouse's Soc. Sec. #** **Work phone #**

EMERGENCY INFORMATION

Name, Address, & Telephone of
A relative not living with you:

How did you hear about our office? Circle all that apply. Direct Mailer Style Magazine Yelp Google B4the Movie

Neighborhood Magazine (please specify) ________________ Harris Center Social Media Folsom Sports Media

Community Event Booth (please specify) _______________ Family/Friend (please specify) ____________________

Please state reason for this visit?

DENTAL INSURANCE INFORMATION (Primary Carrier)	**If you have a dual insurance coverage, complete this for the second coverage.**
Insured's name **DOB** **SS#**	**Insured's name** **DOB** **SS#**
Insured's employer	**Insured's employer**
Insurance Co	**Insurance Co**
Insurance Co Address	**Insurance Co Address**
Phone #	**Phone #**
Group # **Policy #**	**Group #** **Local #**

DENTAL HISTORY

Please check any of the following that apply to you:

-Sensitivity (hot, cold, sweet)	**y/n**
Where? UR LR UL LL	
-Headaches, ear aches, neck or jaw joint pain	**y/n**
-Mouth ulcers or cold sores	**y/n**
-Teeth or fillings breaking	**y/n**
-Grinding or clenching teeth	**y/n**
-Bleeding, swollen or irritated gums	**y/n**
-Loose, tipped or shifting teeth	**y/n**
-Bad breath	**y/n**

Do you have or have you had any of the following?

-Dentures	**y/n**
-Partial dentures	**y/n**
-Braces	**y/n**
-Gum treatments	**y/n**

Please share the following dates:

-Your last cleaning	___ / ___
-Your last oral cancer screening	___ / ___
-Your last complete X-Rays	___ / ___

Name of Previous Dentist ________________________

City _________________________ **State** ________

Phone Number ________________________________

What is the most important thing to you about your future smile and dental health? ____________________

If you could whiten your teeth for a cost anyone could afford, would you do it?

Do you smoke or use chewing tobacco?

How much? For how long?

If I could change my smile, I would:

- **-Make my teeth whiter**
- **-Make my teeth straighter**
- **-Close spaces**
- **-Replace metal fillings with tooth colored restorations**
- **-Repair chipped teeth**
- **-Replace missing teeth**
- **-Replace old crowns that don't match**
- **-Have a smile makeover**

On a scale of 1 – 10, with 10 being the highest rating:

-How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

-Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

____

____

What is the most important thing to you about your dental visit today? ____________________________

MEDICAL HISTORY

Please check any of the following that apply to you:

y/n Allergies (Seasonal)	y/n Excessive Bleeding	y/n Nervousness/Depression	y/n Ulcers
y/n Anemia	y/n Glaucoma	y/n Pacemaker	y/n Snoring
y/n Artificial Heart Valve	y/n Heart Conditions	y/n Phen Fen (1 month +)	y/n Sleep Apnea
y/n Artificial Joints	y/n Heart Murmur	y/n Radiation (head/neck)	y/n Fatigue
y/n Asthma	y/n Hepatitis A	y/n Respiratory Problems	y/n Migraines
y/n Blood Disease	y/n Hepatitis B	y/n Rheumatic Fever	y/n Chronic Pain
y/n Bruise Easily	y/n Hepatitis C	y/n Rheumatism	y/n OTHER (please list)
y/n Cancer	y/n High Blood Pressure	y/n Scarlet Fever	y/n Bisphosphonate
y/n Chemotherapy	y/n HIV/AIDS	y/n Seizures	**For WOMEN Only**
y/n Diabetes	y/n Jaundice	y/n Stomach Problems	y/n Birth Control Pills
y/n Dizziness/Fainting	y/n Kidney Disease	y/n Stroke	y/n Breast-feeding
y/n Drug Addiction	y/n Liver Disease	y/n Thyroid Disease	y/n Pregnant
y/n Emphysema	y/n Mitral Valve Prolapse	y/n Tuberculosis	1-3 mos,3-6 mos,6-9mos,

Do you have an allergy to any of the following?

y/n Aspirin	y/n Codeine	**What medications are you currently taking?**
y/n Erythromycin	Other:	
y/n Latex	________	
y/n Local Anesthetic	________	________________
y/n Nitrous Oxide	________	________________
y/n Penicillin	________	________________

Are you under a physician's care? For what?

____

____

Family Physician ________________________ **Phone Number** ________________________

Patient Signature (or Parent of Child) ______________________ **Date** ______________ **Dentist's Signature** ______________

I consent to the dental practice using my cell phone number to (choose one or both) ☐ call or ☐ text regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time. My cell phone number is (include area code) ____________________ __________ (initial)