Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____ Birth Date: _____ Age: _____
Social Security #: _____ Driver's License # _____ State _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
(Cell) _____ E-Mail: _____ Fax: _____
Address: _____
Street Apartment #

_____
City State Zip
Employer _____ Occupation _____

Dental Benefit Information

Dental Benefit Company: _____ Subscriber's Name: _____
Insurance Plan Name: _____ Phone: _____
Subscriber's SSN: _____ Date of Birth: _____ Phone: _____
Group # _____ Subscribers Employer: _____
ID#: _____ Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

If you have two dental benefits, please fill out the next few lines

Secondary Dental Benefit Company: _____ Subscriber's Name: _____
Insurance Plan Name: _____ Phone: _____
Subscriber's SSN: _____ Date of Birth: _____ Phone: _____
Group # _____ Subscribers Employer: _____
ID#: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Dental Health History Information

It is important that we know your medical and dental history. These facts have a direct bearing on your dental health.

Reason for today's visit _____
How long has it been since you have last seen a Dentist _____ Last Dental Cleaning & Exam _____
Last Full Set Of Xrays (or) Panorex ? _____ Name of Previous Dentist _____
City: _____ State: _____ Phone Number: _____
How would you rate your Present Dental Health? _____ ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Do you wear Dentures? . . . . . ☐ Yes ☐ No Are you Unhappy with them? . . . . . ☐ Yes ☐ No
Would you like to know about Permanent Replacements. . . . . ☐ Yes ☐ No
Are you APPREHENSIVE about Dental Treatment . . . . . ☐ Yes ☐ No
Have you ever had any Periodontal Treatment . . . . . ☐ Yes ☐ No
Do your Gums Bleed or feel tender or Irritated . . . . . ☐ Yes ☐ No
Are you aware of Grinding or Clenching your teeth . . . . . ☐ Yes ☐ No
Do you frequently have Ear Aches or Neck Pain . . . . . ☐ Yes ☐ No
Have you ever worn Braces . . . . . ☐ Yes ☐ No If yes how long ago? _____
Do you get Constant Bad Breath, or a Bitter or Sour Taste. . . . . ☐ Yes ☐ No
Do you Floss? . . . . . ☐ Yes ☐ No If yes, how often _____
Would you like Information on Teeth Whitening? . . . . . ☐ Yes ☐ No
Are your teeth sensitive to . . . . . ☐ Hot ☐ Cold ☐ Sweets
Do You have any loose teeth? . . . . . ☐ Yes ☐ No How often do you brush? _____
Have you had your teeth straightened?. . . . . ☐ Yes ☐ No
Do you normally use a numbing agent for dental treatment? . . . . . ☐ Yes ☐ No
Do you have any fillings that feel rough or areas where food collects? . . . . . ☐ Yes ☐ No

Sign _____ Date _____

Medical Information

Are you presently under a Physician's care? . . . . . ☐ Yes ☐ No
If yes please list Conditions _____

_____

Have you ever had Botox or Derma Fillers? . . . . . ☐ Yes ☐ No
Family Physician: _____ Number: _____
Do you have any health problems that need future clarification? . . . . . ☐ Yes ☐ No
List all Medications that you are presently taking (including Birth Control, Vitamins or over the counter meds)

_____

_____

Are you pregnant? . . . . . ☐ Yes ☐ No Do you smoke?. . . . . ☐ Yes ☐ No

Do you Presently have (or) have ever been Diagnosed with any of the following conditions

- ☐ Abnormal Bleeding
- ☐ Alcohol Abuse
- ☐ Allergies/Hives
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Bones/Joints
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer/Chemotherapy
- ☐ Colitis
- ☐ Cold Sores/ Fever Blisters
- ☐ Contact Lenses
- ☐ Congenital Heart Lesion
- ☐ Cortisone Medication
- ☐ Cosmetic Surgery
- ☐ Diabetes
- ☐ Dlet Restrictions
- ☐ Difficulty Breathing
- ☐ Dizziness
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy / Seizures
- ☐ Fainting Spells
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis A, B, C
- ☐ High Blood Pressure
- ☐ Hiv/Aids Tested
- ☐ Hypoglycemla
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Latex Sensitivity
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervousness
- ☐ Pace Maker
- ☐ Pain In Jaw/Joints
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Conditions
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis or other Lung Problems
- ☐ Tumors
- ☐ Ulcers
- ☐ Venerial Disease

Please list below any other Medical / Dental Conditions that you may have

_____

_____

_____

Are you allergic to (or) have had any Adverse Reactions to any of the following Medications
(Please circle all that apply)

Aspirin Codeine Erythromycin Nitrous Oxide Penicillin Sulfa General Anesthesia

Are you allergic to any medications that are not listed above? (Please specify)
☐ Yes ☐ No (If yes, please list below)

_____

_____

All of the preceding answers and information provided are true. If I ever have any changes in my health, I will inform Doctor Sours and staff at the next appointment without fail.

Patient Signature: _____ Date: _____
Doctor Signature: _____ Date: _____

Cosmetic Information

Is there anything about your smile that you do not like? _____

Are you interested in knowing the options available for a more beautiful smile? _____

Do you like the appearance of your teeth? _____

Are all of your teeth in alignment (straight)? _____

Do you have any missing teeth? Are any chipped? _____

Is your bite comfortable when chewing, biting? _____

Do you have frequent headaches? _____

Do you have any old fillings or dental treatment that you are unhappy with? _____

What would you like to change the most about the appearance of your teeth? _____

_____

Is there anything else that you would like us to know? _____

Referral Information

Whom may we thank for referring you to our practice?

☐ Another patient, friend ☐ Another Doctor ☐ Dental Office ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for:

☐ The patient's spouse ☐ The person responsible for payment ☐ The person responsible for minor

Name: _____ Phone: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____ Birth Date: _____

Social Security #: _____ Driver's License # _____ State ____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip

Patient Signature: _____ Date: _____

FOR [illegible]