

PATIENT NAME



Last _____ First _____ MI _____
 Address: _____ City: _____ State: _____ Zip: _____
 Birthdate: _____ Soc. Sec. #: _____ Single Married Divorced Separated Widowed Partner
 Home Phone: _____ Work Phone: _____ Cell Phone: _____ Employed Homemaker Retired
 Employer _____ Present position: _____ How long held? _____
 Insurance Co. _____ Effective Date: _____ Group # _____
 Spouse / Partner Name: _____ Birthdate: _____ Soc. Sec. #: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 Employer _____ Present position: _____ How long held? _____
 Insurance Co. _____ Effective Date: _____ Group # _____
 Method of payment for dental care: Payment in full at each appointment. Insurance or prepaid program.
 In case of emergency call: Name: _____ Number: _____
 I first learned about this dental office from: Phone Book/specify: _____ Newspaper School Work
 Referred by: Another patient, friend Another patient, relative Dental office doctor or staff member.
 Other _____ Name of person who referred us: _____

DENTAL HISTORY

Have you been having any specific problems? Yes No Describe: _____
 Last dental visit: _____ Purpose: _____ Last complete exam: _____
 Has fear of discomfort kept you from regular visits? Yes No
 Do you think you have active dental disease: Decay? Yes No Gum Disease? Yes No
 Home care: Brush? Yes No Floss? Yes No Other _____
 Do your gums ever bleed? Yes No How often? _____ Are you troubled with bad breath? Yes No
 How do you feel about ever losing your teeth? _____
 Have you had any unusual effects from previous dental treatment? Yes No Describe _____
 Existing dental prosthetics? Yes No Year placed? _____

MEDICAL HISTORY (Confidential, Repeated every five years.)

Medical doctor's name: _____ Last physical exam: _____ Current age: _____
 (Women) Are you pregnant? Yes No Expected delivery date: _____
 Are you under a doctor's care now? Yes No If so, for what reason?: _____
 Are you taking any medication, pills or drugs? Yes No Please list: _____
 Have you ever had any of the following? Indicate YES with check mark (✓).
 Any heart problems Excessive bleeding Typhoid fever Malignancies AIDS Prosthetic valves/joints
 Heart murmur Anemia Nervous problems Radiation treatments Venereal disease Allergy to anesthetics:
 Mitral valve prolapse Rheumatic fever Psychiatric care Asthma Herpes _____
 High blood pressure Measles Hospitalization Stroke Tuberculosis Allergy to medicine/drugs:
 Low blood pressure Mumps Diabetes Ulcer Sinus problems _____
 Circulatory problems Scarlet fever Arthritis Hepatitis Tonsillitis Other allergies:
 Have you had any other serious illness? Yes No Explain: _____
 Have you been hospitalized in the last two years? Yes No Why: _____
 Have you ever taken oral or injected medication to prevent osteoporosis? Yes No
 Have you ever had difficulty with anesthetics? Yes No Explain: _____
 Do you wish to talk to the doctor about any thing not listed? Yes No Comments: _____

AUTHORIZATION: I hereby authorize the doctor(s) and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge. I acknowledge that I am responsible for all fees incurred whether they are covered or not covered by insurance.

Patient Signature _____ Date: _____
 Reviewed by: Doctor _____ Date: _____
 I have received a copy of Family Dental Services Notice of Privacy Practices.
 Patient Signature _____ Date: _____



ADULT PATIENT INFORMATION • DENTAL AND MEDICAL HISTORIES