GENERAL PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____

GENDER: _____ BIRTH DATE: _____

SSN: _____

EMAIL ADDRESS: _____

PHONE NUMBER: _____ TYPE: _____

ADDRESS LINE 1: _____

ADDRESS LINE 2: _____

CITY: _____

STATE/PROVINCE/REGION: _____

POSTAL CODE: _____

HOW DID YOU HEAR ABOUT US?:

SIGNATURE: _____ DATE: _____/_____/_____

TOWN & COUNTRY
DENTISTRY

GENERAL PATIENT INFORMATION

EMPLOYMENT INFORMATION

OCCUPATION: _____

HOW LONG?: _____

EMPLOYER NAME: _____

PLEASE LIST 2 CONTACT NAMES TO WHOM PRACTICE CAN RELEASE PHI INFORMATION (HIPAA)

FIRST NAME: _____

LAST NAME: _____

PHONE NUMBER: _____

FIRST NAME: _____

LAST NAME: _____

PHONE NUMBER: _____

EMERGENCY CONTACT

FIRST NAME: _____ LAST NAME: _____

PHONE NUMBER: _____

INSURANCE

DO YOU HAVE DENTAL INSURANCE? _____

NAME OF INSURED: _____

INSURED'S BIRTH DATE: _____

INSURED'S ADDRESS LINE 1: _____

INSURED'S ADDRESS LINE 2: _____

INSURED'S CITY: _____ INSURED'S STATE: _____

INSURED'S POSTAL CODE: _____

PATIENT'S RELATIONSHIP TO INSURED: _____

INSURED'S EMPLOYER NAME: _____

EMPLOYER'S ADDRESS LINE 1: _____

EMPLOYER'S ADDRESS LINE 2: _____

EMPLOYER'S CITY: _____ EMPLOYER'S STATE: _____

EMPLOYER'S POSTAL CODE: _____

CARRIER NAME: _____

PLAN NAME: _____

INSURANCE

ID #: _____ GROUP #: _____

INSURANCE COMPANY PHONE NUMBER: _____

INSURANCE'S ADDRESS LINE 1: _____

INSURANCE'S ADDRESS LINE 2: _____

INSURANCE'S CITY: _____ INSURANCE'S STATE: _____

INSURANCE'S POSTAL CODE: _____

DO YOU HAVE SECONDARY INSURANCE? _____

NAME OF INSURED: _____

INSURED'S BIRTH DATE: _____

INSURED'S ADDRESS LINE 1: _____

INSURED'S ADDRESS LINE 2: _____

INSURED'S CITY: _____ INSURED'S STATE: _____

INSURED'S POSTAL CODE: _____

PATIENT'S RELATIONSHIP TO INSURED: _____

INSURANCE

INSURED'S EMPLOYER NAME: _____

EMPLOYER'S ADDRESS LINE 1: _____

EMPLOYER'S ADDRESS LINE 2: _____

EMPLOYER'S CITY: _____ EMPLOYER'S STATE: _____

EMPLOYER'S POSTAL CODE: _____

CARRIER NAME: _____

PLAN NAME: _____

ID #: _____ GROUP #: _____

INSURANCE COMPANY PHONE NUMBER: _____

INSURANCE'S ADDRESS LINE 1: _____

INSURANCE'S ADDRESS LINE 2: _____

INSURANCE'S CITY: _____ INSURANCE'S STATE: _____

INSURANCE'S POSTAL CODE: _____

SIGNATURE: _____ DATE: _____/_____/_____

DENTAL HISTORY

REASON FOR VISIT: _____

DATE OF LAST DENTAL VISIT: _____ DATE OF LAST DENTAL X-RAYS: _____

HOW OFTEN DO YOU FLOSS?: _____ HOW OFTEN DO YOU BRUSH?: _____

(PLEASE CHECK ALL THAT APPLY)

- ☐ BAD BREATH
- ☐ BLEEDING, RED, SWOLLEN GUMS
- ☐ BROKEN/LOOSE TEETH OR FILLINGS
- ☐ CLICKING OR POPPING JAW
- ☐ GRINDING TEETH
- ☐ PAIN AROUND EAR/SIDE OF FACE
- ☐ SORES/BLISTERS IN MOUTH

LIST ANY OTHER DENTAL CONCERNS/PAIN: _____

WHAT DID YOU LIKE THE MOST ABOUT YOUR PREVIOUS DENTAL OFFICE?:

WHAT DID YOU LIKE THE LEAST ABOUT YOUR PREVIOUS DENTAL OFFICE?:

ARE YOU INTERESTED IN WHITENING YOUR SMILE?

ARE YOU HAPPY WITH YOUR SMILE? IF NOT, WHAT WOULD YOU CHANGE?:

MEDICAL HISTORY **(PLEASE CHECK ALL THAT APPLY)**

- ☐ ALLERGY - ASPIRIN
- ☐ ALLERGY - CODEINE
- ☐ ALLERGY - LATEX
- ☐ ALLERGY - LOCAL ANESTHETIC
- ☐ ALLERGY - PENICILLIN
- ☐ ALLERGY - SULFA

LIST ANY OTHER ALLERGIES:

- ☐ ABNORMAL (HIGH/LOW) BLOOD PRESSURE
- ☐ AIDS/HIV
- ☐ ANEMIA / BLEEDING PROBLEMS
- ☐ ARTIFICIAL HEART VALVES
- ☐ BLOOD DISEASE
- ☐ CONGENITAL HEART LESIONS
- ☐ HEART PROBLEMS
- ☐ PACEMAKER

- ☐ ARTHRITIS / RHEUMATISM / GOUT
- ☐ ARTIFICIAL JOINTS / BONES
- ☐ ASTHMA
- ☐ CANCER
- ☐ CHEMOTHERAPY
- ☐ DIABETES
- ☐ EMPHYSEMA
- ☐ GLAUCOMA
- ☐ RADIATION TREATMENT (XRAY/COBALT)
- ☐ SHORTNESS OF BREATH (BREATHING PROBLEMS)
- ☐ SINUS TROUBLE
- ☐ STROKE
- ☐ THYROID PROBLEMS
- ☐ TUBERCULOSIS
- ☐ TUMOR / GROWTH ON HEAD / NECK
- ☐ ULCER
- ☐ EPILEPSY
- ☐ FAINTING / DIZZINESS
- ☐ HEADACHES (FREQUENT)
- ☐ HEPATITIS
- ☐ HERPES
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ NERVOUS PROBLEMS
- ☐ PSYCHIATRIC CARE

LIST ANY OTHER MEDICAL ISSUES YOU HAVE:

LIST ANY SERIOUS ILLNESSES / SURGERIES / HOSPITALIZATIONS:

LIST ANY MEDICATIONS YOU ARE TAKING:

- ☐ DO YOU SMOKE?
- ☐ DO YOU DRINK ALCOHOL?
- ☐ HIGH SUGAR INTAKE?
- ☐ PREGNANT

TOWN & COUNTRY
DENTISTRY