so·jodental

PATIENT INFORMATION

FIRST NAME	MI	LAST NAME	PREFERRED NAME	DATE

DATE OF BIRTH	GENDER	SSN	MARITAL STATUS
	☐ M ☐ F		☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER: _____

HOME PHONE	CELL PHONE	WORK PHONE	EXTENSION

EMAIL ADDRESS	COMMUNICATION PREFERENCE FOR CLINICAL INFORMATION (SELECT ONE)
	☐ HOME PHONE ☐ CELL PHONE ☐ WORK PHONE ☐ EMAIL ☐ MAIL

HOME STREET ADDRESS	APARTMENT #	CITY	STATE	ZIP CODE

OCCUPATION	EMPLOYER	EMPLOYER PHONE

EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

NAME OF PERSON WHO REFERRED YOU TO US	OTHER REFERRAL SOURCE
	☐ INSURANCE CO. ☐ MAILER ☐ DRIVE-BY ☐ WEBSITE ☐ OTHER:

RESPONSIBLE PARTY (DISREGARD IF SAME AS ABOVE)

FIRST NAME	MI	LAST NAME	RELATIONSHIP TO PATIENT

DATE OF BIRTH	GENDER	SSN	DRIVER'S LICENSE #	STATE
	☐ M ☐ F			

HOME PHONE	CELL PHONE	WORK PHONE	EXTENSION

EMAIL ADDRESS	PREFFERRED PHARMACY	PHARMACY PHONE

HOME STREET ADDRESS	APARTMENT #	CITY	STATE	ZIP CODE

OCCUPATION/POSITION	HOW LONG?	EMPLOYER	EMPLOYER PHONE

EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

PRIMARY INSURANCE ☐ INSURANCE CARD PROVIDED

SUBSCRIBER FIRST NAME	SUBSCRIBER LAST NAME

DATE OF BIRTH	PATIENT'S RELATIONSHIP TO INSURED
	☐ SELF ☐ SPOUSE ☐ CHILD ☐ PARENT

INSURANCE COMPANY	INSURED'S SSN

INSURANCE COMPANY ADDRESS	STATE	ZIP CODE

EMPLOYER	

GROUP #	POLICY #

GROUP NAME	POLICY EFFECTIVE DATE

SECONDARY INSURANCE ☐ INSURANCE CARD PROVIDED

SUBSCRIBER FIRST NAME	SUBSCRIBER LAST NAME

DATE OF BIRTH	PATIENT'S RELATIONSHIP TO INSURED
	☐ SELF ☐ SPOUSE ☐ CHILD ☐ PARENT

INSURANCE COMPANY	INSURED'S SSN

INSURANCE COMPANY ADDRESS	STATE	ZIP CODE

EMPLOYER	

GROUP #	POLICY #

GROUP NAME	POLICY EFFECTIVE DATE

I verify that the above information is true and correct.

Signature: _____ *Date:* _____

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Patient Name: _____ Date of last dental visit: _____

Reason for today's visit: _____

DENTAL HEALTH

Please check any of the following that apply to your mouth:

- ☐ Acid Reflux
- ☐ Antibiotic Premedication for dental tx
- ☐ Bad Breath
- ☐ Burning mouth/tongue
- ☐ Cankers
- ☐ Cold Sores
- ☐ Clench or Grind Teeth
- ☐ Dry Mouth
- ☐ Gums sollen, tender or bleeding
- ☐ Jaw pain
- ☐ Mouth Breathing
- ☐ Orthodontic Treatment
- ☐ Periodontal Treatment
- ☐ Sensitivity to Pressure
- ☐ Tobacco Use Type: _____ Frequency: _____

How often do you brush? _____ Floss? _____

Have you ever had a reaction to dental anestheic? ☐ Yes ☐ No

Explain: _____

MEDICAL HISTORY

Please select yes or no, if the following conditions apply, or have ever applied to you:

- ☐ Yes ☐ No Allergies
- ☐ Yes ☐ No Aspirin
- ☐ Yes ☐ No Codeine/Narcotics
- ☐ Yes ☐ No Dental Anesthetic
- ☐ Yes ☐ No Iodine
- ☐ Yes ☐ No Latex
- ☐ Yes ☐ No Metals/Nickels/Jewelry
- ☐ Yes ☐ No Penicillin or Amoxicillin
- ☐ Yes ☐ No Sulfa Drugs

Other:_____

Cardiovascular Health

- ☐ Yes ☐ No Angina or Heart Attack
- ☐ Yes ☐ No Coronary Bypass
- ☐ Yes ☐ No Heart Disease or treatment
- ☐ Yes ☐ No Heart valve problem/replacement
- ☐ Yes ☐ No Heart Murmur
- ☐ Yes ☐ No Congenital
- ☐ Yes ☐ No High Blood Pressure
- ☐ Yes ☐ No Irregular Heartbeat/Pacemaker
- ☐ Yes ☐ No Low Blood Pressure
- ☐ Yes ☐ No Past use of Phen-Fen
- ☐ Yes ☐ No Rheumatic Fever
- ☐ Yes ☐ No Stroke

Endocrine/Blood/Immune Health

- ☐ Yes ☐ No Abnormal Bleeding/Bruising
- ☐ Yes ☐ No Anemia
- ☐ Yes ☐ No Blood transfusion
- ☐ Yes ☐ No Cancer

Type:_____

- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Hemophilia
- ☐ Yes ☐ No HIV Infection/AIDS
- ☐ Yes ☐ No Lupus
- ☐ Yes ☐ No Organ transplant
- ☐ Yes ☐ No Rhuematiod Arthritis
- ☐ Yes ☐ No Thyroid Problems

GI/Urinary Health

- ☐ Yes ☐ No Crohn's Disease
- ☐ Yes ☐ No Hepatitis Type: _____
- ☐ Yes ☐ No Kidney disease/Dialysis
- ☐ Yes ☐ No Liver Disease
- ☐ Yes ☐ No Ulcers
- ☐ Yes ☐ No Ulcerative Colitis
- ☐ Yes ☐ No Sexually Transmitted Disease

Are you currently under the care of a physician? ☐ Yes ☐ No

Name of Physician: _____

Muscular-Skeleton/CNS/Mental Health

- ☐ Yes ☐ No Arthritis
- ☐ Yes ☐ No Anxiety/Nervousness
- ☐ Yes ☐ No Dementia/Alzheimer's
- ☐ Yes ☐ No Depression/Bi-polar Disorder
- ☐ Yes ☐ No Epilepsy
- ☐ Yes ☐ No Faining/Dizziness
- ☐ Yes ☐ No History of Alcohol or Drug Abuse
- ☐ Yes ☐ No Joint Replacement
- ☐ Yes ☐ No Mental Health Treatment
- ☐ Yes ☐ No Multiple Sclerosis
- ☐ Yes ☐ No Osteoporosis
- ☐ Yes ☐ No Schizophrenia
- ☐ Yes ☐ No Seizures

Repiratory Health

- ☐ Yes ☐ No Asthma
- ☐ Yes ☐ No COPD
- ☐ Yes ☐ No Chronic Sinus Problems
- ☐ Yes ☐ No Emphysema
- ☐ Yes ☐ No Hay Fever
- ☐ Yes ☐ No Tuberculosis

List all medications you are currently taking

Medication:_____ Condition:_____

Medication:_____ Condition:_____

Medication:_____ Condition:_____

Medication:_____ Condition:_____

Women

Are you currently:

Nursing: ☐ Yes ☐ No

Pregnant: ☐ Yes ☐ No

Taking Birth control pills: ☐ Yes ☐ No

I have answered all health questions to the best of my knowledge.

Signature: _____ *Date:* _____