TRUE
DENTAL

PATIENT INFORMATION

Date: _____ Home Phone: _____ Cell Phone: _____

Name: _____ Pref. Name: _____
Last Name First Name Middle Initial

Sex: ☐ M ☐ F Current Age: _____ Birthdate: _____ SS/Patient ID: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____ Apt: _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for ____ years

Preferred Method of Communication: ☐ Text ☐ Call to the following phone number: _____
☐ Email to the following email address: _____

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____ Employer/School Phone: _____

EMERGENCY CONTACT: _____ **Relationship to Patient:** _____ **Phone:** _____

Pharmacy: _____ Pharmacy Address: _____

Whom may be thank for referring you? _____

PRIMARY DENTAL INSURANCE

Insurance Holder: _____ Relation to Patient: _____
Last Name First Name Middle Initial

Birthdate: _____ Phone: _____ SS/Patient ID: _____

Address **(if different from Patient's)**: _____

City: _____ State: _____ Zip: _____ Apt: _____ Insurance Company: _____

Group #: _____ Member/Subscriber #: _____

Insurance Holder employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Names of other dependents covered under this plan: _____

SECONDARY DENTAL INSURANCE

Is Patient Covered by Additional Dental Insurance? ☐ Yes ☐ No

Insurance Holder: _____ Relation to Patient: _____
Last Name First Name Middle Initial

Birthdate: _____ Phone: _____ SS/Patient ID: _____

Address **(if different from Patient's)**: _____

City: _____ State: _____ Zip: _____ Apt: _____ Insurance Company: _____

Group #: _____ Member/Subscriber #: _____

Insurance Holder employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Names of other dependents covered under this plan: _____

Please Complete Both Sides

DENTAL HISTORY

Reason for Today's Visit: _____

Former Dentist: _____ Address: _____

Date of Last Dental Care: _____ Date of Last Dental X-Rays: _____

Check (✓) if you have had, or currently have, issues with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication you may be taking, could have an important interrelationship with the dentistry you will receive. *Thank you for answering the following questions.*

Primary Care Physician: _____ Date of Last Visit: _____

Please mark "Yes" or "No" to *each* of the following questions:

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No IF YES: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No IF YES: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No IF YES: _____

_____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No IF YES: _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ☐ Yes ☐ No IF YES: _____

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No IF YES: _____

WOMEN: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Other allergies: _____

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics _____

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

AIDS/HIV Positive ○Yes ○No	Cortisone Medicine ○Yes ○No	Hemophilia ○Yes ○No	Radiation Treatments ○Yes ○No
Alzheimer's Disease ○Yes ○No	Diabetes ○Yes ○No	Hepatitis A ○Yes ○No	Recent Weight Loss ○Yes ○No
Anaphylaxis ○Yes ○No	Drug Addiction ○Yes ○No	Hepatitis B or C ○Yes ○No	Renal Dialysis ○Yes ○No
Anemia ○Yes ○No	Easily Winded ○Yes ○No	Herpes ○Yes ○No	Rheumatic Fever ○Yes ○No
Angina ○Yes ○No	Emphysema ○Yes ○No	High Blood Pressure ○Yes ○No	Rheumatism ○Yes ○No
Arthritis/Gout ○Yes ○No	Epilepsy or Seizures ○Yes ○No	High Cholesterol ○Yes ○No	Scarlet Fever ○Yes ○No
Artificial Heart Valve ○Yes ○No	Excessive Bleeding ○Yes ○No	Hives or Rash ○Yes ○No	Shingles ○Yes ○No
Artificial Joint ○Yes ○No	Excessive Thirst ○Yes ○No	Hypoglycemia ○Yes ○No	Sickle Cell Disease ○Yes ○No
Asthma ○Yes ○No	Fainting Spells/Dizziness ○Yes ○No	Irregular Heartbeat ○Yes ○No	Sinus Trouble ○Yes ○No
Blood Disease ○Yes ○No	Frequent Cough ○Yes ○No	Kidney Problems ○Yes ○No	Spina Bifida ○Yes ○No
Blood Transfusion ○Yes ○No	Frequent Diarrhea ○Yes ○No	Leukemia ○Yes ○No	Stomach/Intestinal Disease ○Yes ○No
Breathing Problems ○Yes ○No	Frequent Headaches ○Yes ○No	Liver Disease ○Yes ○No	Stroke ○Yes ○No
Bruise Easily ○Yes ○No	Genital Herpes ○Yes ○No	Low Blood Pressure ○Yes ○No	Swelling of Limbs ○Yes ○No
Cancer ○Yes ○No	Glaucoma ○Yes ○No	Lung Disease ○Yes ○No	Thyroid Disease ○Yes ○No
Chemotherapy ○Yes ○No	Hay Fever ○Yes ○No	Mitral Valve Prolapse ○Yes ○No	Tonsillitis ○Yes ○No
Chest Pains ○Yes ○No	Heart Attack/Failure ○Yes ○No	Osteoporosis ○Yes ○No	Tuberculosis ○Yes ○No
Cold Sores/Fever Blisters ○Yes ○No	Heart Murmur ○Yes ○No	Pain in Jaw Joints ○Yes ○No	Tumors or Growths ○Yes ○No
Congenital Heart Disorder ○Yes ○No	Heart Pacemaker ○Yes ○No	Parathyroid Disease ○Yes ○No	Ulcers ○Yes ○No
Convulsions ○Yes ○No	Heart Trouble/Disease ○Yes ○No	Psychiatric Care ○Yes ○No	Venereal Disease ○Yes ○No
Yellow Jaundice ○Yes ○No			

Have you ever had any serious illness not listed above? If so, please list: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ **Date:** _____