CENTER FOR COSMETIC &
IMPLANT DENTISTRY

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PATIENT INFORMATION

Patient Name: Last, First, Middle (Preferred)			Date of Birth	SSN #
Phone: (Home)	(Cell)	Email:		
Address:				
Family Status: ☐ Single ☐ Married ☐ Other:			Occupation:	
Patient (Guardian)'s Employer	Work Address:		Work Phone:	
Spouse name: Last, First, Middle		Spouse's Occupation:	Spouse's Employer:	
Spouse's work address:				

INSURANCE AND FINANCIAL INFORMATION

Insurance company name:	Insurance phone:	Group #:
Insurance address:		ID #:
Subscriber's Name:	Patient's relationship to subscriber:	
Subscriber's DOB:	Employer:	Employer Address:

EMERGENCY CONTACT INFORMATION

Name:		Relationship:
Home phone:	Work phone:	Cell:

MEDICAL HEALTH INFORMATION

Name of Physician/and their specialty:	Phone:
Physician's address:	Fax:
Most recent physical exam:	General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Describe any current medical treatment, impending surgery, or other treatment that may affect your dental treatment:	
Have you been admitted to a hospital or need emergency care? Yes ☐ No ☐	

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV Positive	☐ Fainting	☐ Nervous Disorders	☐ Ulcers
☐ Allergies: _____	☐ Glaucoma	☐ Neurologic Condition	☐ Vascular Surgery
☐ Anemia	☐ Growths	☐ Pacemaker	☐ Penicillin Allergy
☐ Artificial Heart Valve	☐ Hay Fever	☐ Pneumonia	☐ Venereal Disease
☐ Artificial Joints	☐ Head Injuries	☐ Radiation Treatment	☐ Codeine Allergy
Date: _____	☐ Heart Disease/Failure	☐ Respiratory Problems	☐ Penicillin Allergy
☐ Asthma	☐ Heart Murmur/MVP	☐ Emphysema	☐ Latex Allergy
☐ Blood Disease	☐ Hemodialysis	☐ Rheumatic Fever	☐ Aspirin Allergy
☐ Cancer	☐ Hepatitis _____	☐ Rheumatism	☐ Ibuprofen Allergy
☐ Chemotherapy	☐ High Blood Pressure	☐ Sinus Problems	☐ Acetaminophen Allergy
☐ Diabetes	☐ Jaundice	☐ Stomach Problems	☐ Local Anesthesia Allergy
☐ Dizziness	☐ Kidney Disease	☐ Stroke	☐ Ohers:
☐ Epilepsy	☐ Liver Disease	☐ Thyroid Disease	☐ _____
☐ Excessive Bleeding	☐ Mental Disorders	☐ Tuberculosis	☐ _____

Please describe in details of the checked items:

_____

List medicines taken within the last two years

Drug	Purpose	Drug	Purpose

I certify that I have read and understand the above information. To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform my doctor at the next appointment without fail. I will not hold my dentist or any other member of her staff responsible for any errors or omissions made in this completion of this form.

Signature of patient, parent or guardian: _____ Date: _____

Doctor's signature: _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Friend ☐ Relative ☐ Dental Office ☐ Newspaper ☐ Magazine ☐ Internet ☐ Others: _____

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

DENTAL HEALTH INFORMATION		
Date of most recent dental exam and cleaning:	Previous Dentist:	
Most recent treatment:		Date:
Major dental treatment in the past:		Date:

What is your immediate concerns: _____

1. Have you ever had any unfavorable dental experience?_____ Yes ☐ No ☐
2. Have you ever had any complications following dental treatment? _____ Yes ☐ No ☐
3. Have you had trouble getting numb or had any reaction to local anesthesia? _____ Yes ☐ No ☐
4. Have you had braces, or orthodontic treatment or have your bite adjusted? _____ Yes ☐ No ☐
5. Do you use tobacco in any form ? ☐ Smoke ☐ Dip ☐ Chew ☐ Pips # daily: _____ Years _____ Yes ☐ No ☐
6. Have you had an injury to your face or jaw? _____ Yes ☐ No ☐
7. Have you had surgery fro a tumor or growth on you mouth, face or neck? _____ Yes ☐ No ☐
8. Is there anything about the appearance of your teeth you would like to change? _____ Yes ☐ No ☐
9. Have you ever whitened (bleached) your teeth? _____ Yes ☐ No ☐
10. Have you felt self conscious about the appearance of your teeth? _____ Yes ☐ No ☐
11. Do you have problems with your jaw joints? (pain, click, locking, popping, limited opening) _____ Yes ☐ No ☐
12. Do you have any problems chewing gum or hard food? or wake up feeling your jaw tired? _____ Yes ☐ No ☐
13. Do you have problem with your bite? _____ Yes ☐ No ☐
14. Do you grind your teeth at night or clench your teeth at day time?_____ Yes ☐ No ☐
15. Do you chew ice, bite your nails, use your teeth to hold objects or have other oral habits?_____ Yes ☐ No ☐
16. Do you wear or have your worn bite appliance? _____ Yes ☐ No ☐
17. Do you have any pain or sensitivity of your teeth? _____ Yes ☐ No ☐
18. Have you ever broken teeth, chipped teeth, or cracked filling?_____ Yes ☐ No ☐
19. Do you frequently get food caught between your teeth? _____ Yes ☐ No ☐
20. Do your gum bleed or feel painful when brushing or flossing? _____ Yes ☐ No ☐
21. Have you been told that you have gum disease or bone loss around teeth? _____ Yes ☐ No ☐
23. Do you or have you had crowns, bridges, veneers? Yes ☐ No ☐ Any problems with them?_____ Yes ☐ No ☐
24. Do you or have you had dental implants? Yes ☐ No ☐ Any problems with them?_____ Yes ☐ No ☐
25. Do you wear a denture or partial? Yes ☐ No ☐ Any problems with them?_____ Yes ☐ No ☐

Signature of patient, parent or guardian: _____ Date: _____

Doctor's signature: _____ Date: _____