**PATIENT INFORMATION Today's Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First

MI

Last

 Male Female Married Single Child Other

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TDL#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (Home) :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( Work):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EXT: \_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Contact Method:** Home Phone Work Phone Cell Phone Email Text

**Preferred Appointment Confirmation Method:**  Home Phone Work Phone Cell Phone Email Text

**Preferred Method to Schedule Appointments:** Home Phone Work Phone Cell Phone Email Text

Home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street

City/State

 Zip Code

Work address: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Zip Code

Street

City/State

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Insurance**

*Primary Insurance Information*

Insured Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Insured: Self Spouse Child

Insured SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured DOB\_\_\_\_/\_\_\_\_/\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list other members of your immediate family who are patients in our office \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Or did you find us on your own?**

\_\_\_Website

\_\_\_Social Media

\_\_\_Lumineer

\_\_\_Insurance Company

\_\_\_Walk in

\_\_\_Post Card

\_\_\_Other

 **Can we thank someone for referring you?**

Family Member\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Coworker\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Friend \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is the reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Last Dental Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you prefer Nitrous Oxide (laughing gas) during dental procedure?**  Yes No

**Are you interested in whitening your teeth?** YesNo

**Are you interested in sedation dentistry?** Yes No

**Why did you leave your previous dentist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If you could change your smile, what would you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you prefer to see a particular doctor in our practice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEALTH QUESTIONNAIRE**

**Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality of care. All information you provide will be kept confidential.**

**\*PLEASE ANSWER BY CIRCLING Yes (Y) or No (N) FOR EACH INDIVIDUAL QUESTION**

1. Are you in good health? ............................................................................................................ Y N

2. Has there been any change in your general health in the past year?……………………...…Y N

3. Date of last check up by physician \_\_\_\_/\_\_\_\_/\_\_\_\_

4. Are you currently in a physician's care? ....................................................................................Y N

If so, what for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treating Physician's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Have you had any serious illness, operations, or hospitalizations? ………………………………Y N

If so, describe and give approximate dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Have you ever had intravenous sedation or general anesthesia………………………………..Y N

 Were there any adverse effects? ………………………………………………………………………Y N

7. Do you generally tolerate dental treatment well? ………………………………………………....Y N

8. Are you currently taking any medications? ............................................................................... Y N

If so, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DO YOU HAVE OR HAVE YOU EVER HAD:**

* Low Blood Pressure Y N
* Lung Disease Y N
* Mitral Valve Prolepses Y N
* Osteoporosis Y N
* Pain in Jaw Joints Y N
* Parathyroid Disease Y N
* Psychiatric Care Y N
* Radiation Treatment Y N
* Renal Dialysis Y N
* Rheumatic Fever Y N
* Shingles Y N
* Sickle Cell Disease Y N
* Sinus Trouble Y N
* Spinal Bifida Y N
* Stomach Disease Y N
* Stroke Y N
* Swelling of Limbs Y N
* Thyroid Disease Y N
* Tonsillitis Y N
* Tuberculosis Y N
* Tumors or Growths Y N
* Ulcers Y N
* Venereal Disease Y N
* Yellow Jaundice Y N
* Excessive Bleeding Y N
* Excessive Thirst Y N
* Fainting Spells/Dizziness Y N
* Frequent Cough Y N
* Frequent Diarrhea Y N
* Frequent Headaches Y N
* Genital Herpes Y N
* Glaucoma Y N
* Hay Fever Y N
* Heart Attack/Failure Y N
* Heart Murmur Y N
* Heart Pacemaker Y N
* Heart Trouble/Disease Y N
* Hemophilia Y N
* Hepatitis A Y N
* Hepatitis B or C Y N
* Herpes Y N
* High Blood Pressure Y N
* High Cholesterol Y N
* Hives or Rash Y N
* Hypoglycemia Y N
* Irregular Heartbeat Y N
* Kidney Problems Y N
* Leukemia Y N
* Liver Disease Y N
* AIDS/HIV Positive Y N
* Alzheimer’s Disease Y N
* Anaphylaxis Y N
* Anemia Y N
* Angina Y N
* Arthritis/Gout Y N
* Artificial Heart Valve Y N
* Artificial Joint Y N
* Asthma Y N
* Blood Disease Y N
* Blood Transfusion Y N
* Breathing Problems Y N
* Bruise Easily Y N
* Cancer Y N
* Chemotherapy Y N
* Chest Pain Y N
* Cold Sores/Fever Blisters Y N
* Congenital Heart Disorder Y N
* Convulsions Y N
* Cortisone Medicine Y N
* Diabetes Y N
* Drug Addiction Y N
* Easily Winded Y N
* Emphysema Y N
* Epilepsy or Seizures Y N

**ARE, YOU ALLERGIC TO OR HAD A BAD REACTION FROM:**

* Local anesthetics (Novocain-like drugs)? Y N
* Penicillin, Amoxicillin, Cephalosporins? Y N
* Other antibiotics? Y N
* Barbiturates, sedatives? Y N
* Aspirin, ibuprofen, or other pain medicines? Y N
* Codeine or other narcotics or opiods? Y N
* Latex? Y N
* Other allergies or reactions? Y N

Please List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Do you smoke? Y N

How Much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Do you use alcohol? Y N

How Much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Do you use spit tobacco? Y N

How Much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Metal? Y N
* Sulfa Drugs? Y N
* Acrylic? Y N

Do you have any other diseases, conditions or problems not listed above that you think the doctor should know about? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any additional comments or concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WOMEN ONLY: Pregnant Trying to get pregnant Breast Feeding Birth Control**

 **Taking hormonal replacement**

**I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment, to the best of my knowledge; the information above is complete and accurate.**

**Date\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ Signature of person completing form\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**