FAMILY TREE
DENTISTRY

Patient Information

Name: _____ Date of Birth: _____ Sex: _____ Married (Y/N): ___
SSN: _____ Drivers License #: _____
Cell Phone: _____ Work Phone: _____
Home Phone: _____
Email:
_____

Prefered contact method: Text Email Wireless Phone Home Phone Work Phone
Prefered method for confirmations: Text Email Wireless Phone Home Phone Work Phone

How did you hear about our office?_____

Address

Address:_____
Address 2: _____
City: _____ State: _____ Zip: _____

Insurance Policy 1

Subscriber Name:_____ Relationship to Subscriber: _____
Subscriber's Date of Birth: _____
Insurance Company:_____ Subscriber ID: _____
Phone: _____
Employer:_____
Group Name:_____ Group #:_____

Insurance Policy 2

Subscriber Name:_____ Relationship to Subscriber: _____
Subscriber's Date of Birth: _____
Insurance Company:_____ Subscriber ID: _____
Phone: _____
Employer:_____
Group Name:_____ Group #:_____

FAMILY TREE
DENTISTRY

Scribers Date of Birth: _____

Medical history

Do you have a personal physician? ❑ Yes ❑ No
Physician's Name: _____
Physician's Phone: _____
Date of last visit: _____

Have you had any metal rods, pins or implants placed? ❑ Yes ❑ No

Are you taking any medications (list below)? ❑ Yes ❑ No

_____
_____
_____
_____

Have you ever had any surgical procedures(list below)? ❑ Yes ❑ No

_____
_____
_____

Conditions

Yes	No		Yes	No		Yes	No	
❑	❑	Abnormal Bleeding	❑	❑	Heart Murmur	❑	❑	Psychiatric Problems
❑	❑	Artificial Heart Valve	❑	❑	Hepatitis (A, B or C)	❑	❑	Radiation/Chemotherapy
❑	❑	Asthma	❑	❑	High Blood Pressure	❑	❑	Rheumatic Fever
❑	❑	Blood Transfusion	❑	❑	Joint Replacement	❑	❑	Seizures
❑	❑	Cancer	❑	❑	Kidney Problems	❑	❑	Sickle Cell Disease
❑	❑	Congenital Heart Defect	❑	❑	Liver Disease	❑	❑	Sinus Problems
❑	❑	Diabetes	❑	❑	Low Blood Pressure	❑	❑	Stroke
❑	❑	HIV+ AIDS	❑	❑	Mitral Valve Prolapse	❑	❑	Thyroid Problems
❑	❑	Heart Attack	❑	❑	Pacemaker			

FAMILY TREE
DENTISTRY

Allergies

Yes	No	Allergies
❑	❑	Aspirin
❑	❑	Codeine
❑	❑	Penicillin
❑	❑	Other Antibiotics
❑	❑	Sulfa drugs
❑	❑	"Novocaine"
❑	❑	Latex

Other Allergies (list below):

_____

_____

_____

_____

_____

_____

Dental History

Reason for today's visit? _____

Are you in pain? _____

	YES	NO
Do you require Antibiotics before dental treatment?	☐	☐
Have you ever had "gum treatment" (deep cleanings)?	☐	☐
Do you like the color of your teeth?	☐	☐
Are you teeth Sensitive to Heat, Cold, Sweets or Biting?	☐	☐
Does food catch between your teeth?	☐	☐
Does floss catch between your teeth?	☐	☐
Do your gums bleed when brushing?	☐	☐
Are you dissatisfied with your teeth in any way?	☐	☐
Do you use any tobacco products?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Do you have headaches, earaches or jaw pain?	☐	☐

New patients:

Date of last Dental Appointment?_____

Date of last X-Rays? _____

Name/Location of former dentist? _____

FAMILY TREE
DENTISTRY

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical or dental status.

Signature: _____ Date: _____