Form 401D

Welcome to Our Practice!

Today's Date ___/___/___ Patient # __________

PATIENT INFORMATION

❒ Mr ❒ Ms ❒ Miss ❒ Mrs ❒ Dr

Name ____________________

Address ____________________

City/St/Zip ____________________

How long at current address? __________

Phone # (____) __________ SS # __________

Other Phone # (____) __________

Birth Date ___/___/___ Age __ ❒ Male ❒ Female

❒ Single ❒ Married ❒ Dependent ❒ Other

E-mail ____________________

Referred by ____________________

RESPONSIBLE PARTY

IF OTHER THAN PATIENT

Relationship to patient ____________________

Name ____________________

Address ____________________

City/St/Zip ____________________

How long at current address? __________

Phone # (____) __________ SS # __________

Birth Date ____/____/____ Age ____ ❒ Male ❒ Female

EMPLOYMENT INFORMATION

Employer ____________________

Work Phone (____) ____________________

Occupation ____________________

How Long at Current Job? __________

INSURANCE

Insurance Company ____________________

Address ____________________

City/St/Zip ____________________

Phone # (_____) ____________________

Insured's Employer ____________________

Insured's Name ____________________

Relationship to Patient ____________________

Insured's SS # or Membership # ____________________

POLICY / GROUP NUMBER ____________________

PLEASE CHECK ALL DENTAL CONCERNS THAT APPLY TO YOU:

TEETH:

❒ Broken or Chipped
❒ Crooked
❒ Decay
❒ Difficulty Chewing
❒ Discolored
❒ Food Trap Areas
❒ Grinding or Clenching
❒ Loose or Missing Filling
❒ Loose Tooth or Teeth
❒ Missing Tooth or Teeth
❒ Mouth Sores
❒ Sensitive to Temperature Changes
❒ Sensitive to Sweets
❒ Tooth Pain

GUMS:

❒ Bleeding
❒ Pimple or Bump
❒ Sore or Sensitive

JAW / FACIAL PAIN PROBLEMS:

❒ Facial Pain
❒ Frequent Headaches
❒ Jaw Clicks
❒ Jaw Pain
❒ Pain in Cheeks or Temples

OTHER CONCERNS OR REASONS FOR VISIT:

____

____

❒ Here for a Periodic Examination. No Specific Known Dental Problems.

PAST DENTAL HISTORY:

Last Dental Visit ____________________

Dental Visit Frequency Every:
___ Months ___ Years ___ As Needed

❒ Have Tooth Replacements such as Dentures, Partials, Bridges or Implants?
❒ Dissatisfied ❒ Satisfied

Other: ____________________

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LIST ANY MEDICATIONS / SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION AND NAME:

Y ❑ N ❑ Antibiotics
Y ❑ N ❑ Aspirin
Y ❑ N ❑ Codeine
Y ❑ N ❑ Iodine
Y ❑ N ❑ Latex
Y ❑ N ❑ Local Anesthetics
Y ❑ N ❑ Metals
Y ❑ N ❑ Novocaine
Y ❑ N ❑ Penicillin
Y ❑ N ❑ Plastic
Y ❑ N ❑ Sedatives
Y ❑ N ❑ Sleeping Pills
Y ❑ N ❑ Sulfa Drugs
Y ❑ N ❑ Other

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN AND NAME:

Y ❑ N ❑ Antibiotics ________
Y ❑ N ❑ Anticoagulants ________
Y ❑ N ❑ Aspirin ________
Y ❑ N ❑ Blood Thinners ________
Y ❑ N ❑ Blood Pressure ________
Y ❑ N ❑ Codeine ________
Y ❑ N ❑ Cortisone ________
Y ❑ N ❑ Diet Pills ________
Y ❑ N ❑ Digestive Aids ________
Y ❑ N ❑ Heart Medication ________
Y ❑ N ❑ Insulin ________
Y ❑ N ❑ Muscle Relaxants ________
Y ❑ N ❑ Pain Medication ________
Y ❑ N ❑ Sleeping Pills ________
Y ❑ N ❑ Tranquilizers ________
Y ❑ N ❑ Other ________

MEDICAL HISTORY:

Y ❑ N ❑ Anemia
Y ❑ N ❑ Arthritis
Y ❑ N ❑ Artificial Joint or Prosthetic
Y ❑ N ❑ Asthma
Y ❑ N ❑ Bleeding Easily After A Cut
Y ❑ N ❑ Cancer
Y ❑ N ❑ Chronic Mouth Dryness
Y ❑ N ❑ Current Pregnancy
Y ❑ N ❑ Depression
Y ❑ N ❑ Diabetes
Y ❑ N ❑ Digestive Problems
Y ❑ N ❑ Dizziness
Y ❑ N ❑ Epilepsy or Seizures
Y ❑ N ❑ Headaches
Y ❑ N ❑ Heart Murmur
Y ❑ N ❑ Heart Pacemaker
Y ❑ N ❑ Heart Palpitations
Y ❑ N ❑ Heart Valve Replacement
Y ❑ N ❑ Heart Valves Damaged
Y ❑ N ❑ Hepatitis
Y ❑ N ❑ High Blood Pressure
Y ❑ N ❑ Immune System Disorder
Y ❑ N ❑ Injury to: ❑ Face ❑ Mouth ❑ Neck ❑ Teeth
Y ❑ N ❑ Kidney Problems
Y ❑ N ❑ Liver Problems
Y ❑ N ❑ Low Blood Pressure
Y ❑ N ❑ Osteoporosis
Y ❑ N ❑ Radiation Treatment
Y ❑ N ❑ Respiratory Problems
Y ❑ N ❑ Rheumatic Fever
Y ❑ N ❑ Scarlet Fever
Y ❑ N ❑ Sinus Problems
Y ❑ N ❑ Tuberculosis
Y ❑ N ❑ Other ________

Y ❑ N ❑ Do you smoke? If yes, how much and how often? ________
Y ❑ N ❑ Do you use oral tobacco? If yes, how much and how often? ________
Y ❑ N ❑ Do you drink alcohol? If yes, how much and how often? ________
Y ❑ N ❑ Do you take herbal supplements? If yes, please list: ________

____

DESCRIBE ANY SERIOUS ILLNESS, MAJOR SURGERY OR CONDITIONS NOT LISTED ABOVE:

mm/yy: ____/ ____ ________
mm/yy: ____/ ____ ________
mm/yy: ____/ ____ ________

ARE YOU UNDER A PHYSICIANS CARE?

Practitioner Specialty Treatment & Approx. Date

____
____

Primary Care Physician ________

IF VISIT IS DUE TO ACCIDENT, PLEASE DESCRIBE BELOW:

____

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Signed ________ Date ____/____/____

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