

Dental Dreams, LLC

MAKING DREAM SMILES A REALITY

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PATIENT INFORMATION

Date _____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Home Phone _____ Birthdate _____ Social Security # _____

Cell/other phone _____ Email address _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

PRIMARY SUBSCRIBER OF INSURANCE PLAN INFORMATION

Name _____
Last First Middle

Mailing Address _____
Street City Zip

Home phone _____ Work phone _____

Cell/other phone _____ Email address _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____

Dependent listed on plan: _____ Birthdate: _____ Relationship to Patient _____

Dependent listed on plan: _____ Birthdate: _____ Relationship to Patient _____

Dependent listed on plan: _____ Birthdate: _____ Relationship to Patient _____

Dependent listed on plan: _____ Birthdate: _____ Relationship to Patient _____

DENTAL INSURANCE INFORMATION

Insurance Company _____ Group No. _____ Member ID No. _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes _____ No _____ If yes:

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Member ID No. _____

Insurance Co. Address _____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

I understand that, where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

- Yes No Are you taking any medication? _____
- Yes No Are you allergic to any medication? _____
- Yes No Do you have a history of a major illness? _____
- Yes No Have you had any operations? _____
- Yes No Have you ever been involved in a serious accident? _____
- Yes No Have seen a physician in the last 12 months? Why? _____

Circle any of the medical conditions below that you have had or currently have.

- | | | | |
|------------------------------|----------------------------|--------------------------|------------------------|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation/Chemotherapy |
| Asthma or Hayfever | Gastrointestinal Disorders | HIV / Aids | Rheumatic Fever |
| Bone Disorders | Heart Problems | Kidney problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer |
- Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____

- Yes No Are you presently in any dental pain? _____
- Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
- Yes No Have you ever lost or chipped any teeth? _____
- Yes No Have there been any injuries to face, mouth, or teeth? _____
- Yes No Is any part of your mouth sensitive to temperature? Where? _____
- Yes No Is any part of your mouth sensitive to pressure? Where? _____
- Yes No Do your gums bleed when you brush? _____
- Yes No Do you have any type of thumb or tongue habit? _____
- Yes No Are you a mouth breather? _____
- Yes No Have you ever seen an orthodontist? If yes, who and when? _____
- Yes No What is your attitude toward receiving orthodontic treatment? _____
- Yes No Has anyone in your family received orthodontic treatment? _____
- Yes No How did they feel about the result? _____
- Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
- Yes No Are you aware of your jaw clicking or popping? _____
- Yes No Are you aware of clenching your teeth during the day? _____
- Yes No Have you ever been told that you grind your teeth? _____
- Yes No Do you have "tension" headaches? _____
- Yes No Have you ever experienced chronic ringing in your ears? _____
- Yes No If the patient is under age 16, height of parents? Mom _____ Dad _____
- Yes No Are you aware that some appointments will be during school/work hours? _____
- Yes No Please list some hobbies or interests _____
- Female Patients only:
- Yes No Are you pregnant? _____
- Yes No Has menstruation started? _____

Signature: _____ Date: _____