



**PATIENT INFORMATION**

Please print and fill out as much information as possible.

Name \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Where and when are the best times to reach you? \_\_\_\_\_

Date of Birth \_\_\_ / \_\_\_ / \_\_\_ Age \_\_\_ Sex \_\_\_ Marital Status \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_

**PARENT / RESPONSIBLE PARTY**

Please fill out this section if you are not the patient.

Name \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**INSURANCE INFORMATION / POLICY HOLDER**

**PRIMARY INSURANCE** \_\_\_\_\_

Subscriber ID# \_\_\_\_\_ Group # \_\_\_\_\_

Name of Cardholder \_\_\_\_\_ Date of Birth \_\_\_ / \_\_\_ / \_\_\_ SS # \_\_\_\_\_

**SECONDARY INSURANCE** \_\_\_\_\_

Subscriber ID# \_\_\_\_\_ Group # \_\_\_\_\_

Name of Cardholder \_\_\_\_\_ Date of Birth \_\_\_ / \_\_\_ / \_\_\_ SS # \_\_\_\_\_

**ADDITIONAL INFORMATION**

Emergency Contact Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about Main Street Dental?  Ad  Internet  Drive by  Family or Friend  Insurance

If referred by family or friend, who may we thank? \_\_\_\_\_

Other family members seen by us? \_\_\_\_\_

**DENTAL HISTORY**

Who is your current or previous Dentist? \_\_\_\_\_ Date of Last Dental Visit \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Why have you come to the Dentist today? \_\_\_\_\_

Are you currently in pain?  Yes  No

How is your current dental health?  Good  Fair  Poor

Do you require antibiotics before dental treatment?  Yes  No

Have you ever had a serious/difficult problem associated with any previous dental work?  Yes  No

Have you ever had gum treatment?  Yes  No

Do you now or have you ever experienced pain/ discomfort in you jaw joint (TMJ/TMD)?

Do you like your smile?  Yes  No

How many times a week do you floss? \_\_\_\_\_ How many times a day do you brush? \_\_\_\_\_

Type of bristles?  Soft  Medium  Hard

How long do you use a toothbrush before replacing it? \_\_\_\_\_

Are your teeth sensitive to heat, cold, or anything else? \_\_\_\_\_

Have you lost any teeth?  Yes  No If yes, why? \_\_\_\_\_

**MEDICAL HISTORY**

How is your current physical health?  Good  Fair  Poor

Do you smoke or use tobacco in any other form?  Yes  No

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

Are you taking any prescriptions/over the counter or herbal supplemental drugs?  Yes  No

If so, please list each one: \_\_\_\_\_

Have you ever taken Fosamax, or any other Bisphosphonate?  Yes  No

Have you ever taken Phen-Fen?  Yes  No

**ALLERGIES**

Are you allergic to any of the following?

Aspirin

Erythromycin

Tetracycline

Codeine

Latex

Other

Dental Anesthetics

Penicillin

Please list any other drugs/materials that you are allergic to: \_\_\_\_\_

**MEDICAL CONDITIONS**

Have you ever had any of the following diseases or medical problems?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Abnormal Bleeding              | <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Osteoporosis/Paget's Disease |
| <input type="checkbox"/> Alcohol/Drug Abuse             | <input type="checkbox"/> Hay Fever                   | <input type="checkbox"/> Pacemaker                    |
| <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Heart Attack                | <input type="checkbox"/> Psychiatric Problems         |
| <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Heart Murmur                | <input type="checkbox"/> Radiation Treatment          |
| <input type="checkbox"/> Artificial Bones/Joints/Valves | <input type="checkbox"/> Heart Surgery               | <input type="checkbox"/> Scarlet Fever                |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Hemophilia                  | <input type="checkbox"/> Seizures                     |
| <input type="checkbox"/> Blood Transfusion              | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Shingles                     |
| <input type="checkbox"/> Cancer/Chemotherapy            | <input type="checkbox"/> Herpes/Fever Blisters       | <input type="checkbox"/> Sickle Cell Disease          |
| <input type="checkbox"/> Colitis                        | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Sinus Problems               |
| <input type="checkbox"/> Congenital Heart Defect        | <input type="checkbox"/> HIV+ /AIDS                  | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Hospitalized for Any Reason | <input type="checkbox"/> Thyroid Problems             |
| <input type="checkbox"/> Difficulty Breathing           | <input type="checkbox"/> Kidney Problems             | <input type="checkbox"/> Tuberculosis (TB)            |
| <input type="checkbox"/> Emphysema                      | <input type="checkbox"/> Liver Disease               | <input type="checkbox"/> Ulcers                       |
| <input type="checkbox"/> Epilepsy                       | <input type="checkbox"/> Low Blood Pressure          | <input type="checkbox"/> Venereal Disease             |
| <input type="checkbox"/> Fainting Spells                | <input type="checkbox"/> Lupus                       |   |
| <input type="checkbox"/> Frequent Headaches             | <input type="checkbox"/> Mitral Valve Prolapse       |   |

Please list any other serious medical condition(s) that you have ever had: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FOR WOMEN**

Are you using a prescribed method of birth control?  Yes  No  
 Are you pregnant?  Yes  No Week# \_\_\_\_ Are you nursing?  Yes  No

**SIGNATURE & ACKNOWLEDGEMENT**

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 status.

\_\_\_\_\_ Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Patient or Responsible Party Signature