EMINENT DENTAL
TREATING YOU LIKE FAMILY SINCE 1985

ADULT PATIENT INFORMATION

Date_____

Patient's name_____
Last First Middle

Residence _____
Street City Zip

Mailing Address_____
Street City Zip

Home phone_____ Work phone _____

Cell Phone_____ Birthdate_____ Social Security # _____

Email Address_____ Marital Status: Single__ Married__ Widowed__ Separated__ Divorced___

Employer_____ Occupation_____ No. years employed _____

Spouse or Parent/Guardian's Name_____Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Social Security # _____ Birthdate _____ Phone_____

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

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security # _____

Insurance Company_____ Group No._____ Local 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._____ Local No._____

Insurance Co. Address_____ Phone No. _____

EMERGENCY INFORMATION

Name_____

Complete address _____
Street City Zip

Phone _____

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

Signature _____

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 medical treatment now? _____
Yes No Have you ever been hospitalized for surgery or serious illness? _____
Yes No Are you taking any medication (prescription or non-prescription)? Please describe. _____
_____
Yes No Have you ever taken Fen-Phen/Redux? _____
Yes No Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing bisphosphonates?_____
_____
Yes No Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours? _____
Yes No Do you use tobacco products?_____
Yes No Are you wearing contact lenses? _____

Are you allergic to or have any reactions to the following? Please circle all that apply.

Local Anesthetics (e.g. Novocain)	Barbiturates	Aspirin	Other:
Penicillin or other Antibiotics	Sedatives	Latex Rubber	_____
Sulfa Drugs	Iodine	Any metals (e.g. nickel)	_____

Female Patients only:

Yes No Are you pregnant or think you may be pregnant? _____
Yes No Are you nursing? _____
Yes No Are you taking oral contraceptives?_____

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

High Blood Pressure	Kidney Diseases	Cancer	Tuberculosis
Heart Attack	HIV/AIDS	Arthritis	Radiation Therapy
Rheumatic Fever	Thyroid Problem	Joint Replacement or Implant	Glaucoma
Swollen Ankles	Heart Disease	Hepatitis/Jaundice	Recent Weight Loss
Fainting/Seizures	Cardiac Pacemaker	Liver Disease	Sexually Transmitted Disease
Asthma	Heart Murmur	Stomach Troubles/Ulcers	Heart Trouble
Low Blood Pressure	Angina	Chest Pains	Respiratory Problems
Epilepsy/Convulsions	Frequently Tired	Easily Winded	Mitral Valve Prolapse
Leukemia	Anemia	Stroke	Other:
Diabetes	Emphysema	Hay Fever/Allergies	_____

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

DENTAL HISTORY

Previous Dentist _____ Date of last visit_____
What concerns you most about your teeth? _____

Yes No Do your gums bleed while brushing or flossing? _____
Yes No Are your teeth sensitive to hot or cold liquids/foods?_____
Yes No Are your teeth sensitive to sweet or sour liquids/foods? _____
Yes No Do you feel pain to any of your teeth? _____
Yes No Do you have any sores or lumps in or near your mouth? _____
Yes No Have you had any head, neck or jaw injuries?_____
Yes No Have you experienced any of the following problems in your jaw. Please circle all that apply:
Pain (joint, ear, side of face) *Clicking* *Difficulty in opening/closing* *Difficulty in chewing*
Yes No Do you have frequent headaches? _____
Yes No Do you clench or grind your teeth? _____
Yes No Do you bite your lips or cheeks frequently?_____
Yes No Have you had any difficult extractions in the past? _____
Yes No Have you ever had any prolonged bleeding following extractions? _____
Yes No Have you had any orthodontic treatment? _____
Do you wear dentures or partials? If so, please list date of placement:_____
Yes No Have you ever received oral hygiene instructions regarding the care of your teeth/gums?_____
Yes No Do you like your smile? _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.

Signature: _____Date: _____