Patient Information

CONFIDENTIAL

(Please print) Date ____________

Name ______________________ (First / MI / Last) Birthdate ____________ Home phone ____________

Address ______________________ City ____________ State ______ Zip ____________

E-mail ______________________ Cell phone ____________

Check appropriate box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Patient's or parent/guardian's employer ______________________ Work phone ____________

Business address ______________________ City ____________ State ______ Zip ____________

Spouse or parent/guardian's name ____________ Employer ____________ Work phone ____________

If patient is a student, name of school/college ______________________ City ____________ State ______

Whom may we thank for referring you? ______________________

Person to contact in case of an emergency ______________________ Phone ____________

Responsible Party

Name of person responsible for this account ______________________ Relationship to patient ____________

Address ______________________ Home phone ____________

E-mail ______________________ Cell phone ____________

Driver's license # ____________ Birthdate ____________ Social Security # ____________

Employer ______________________ Work phone ____________

Is this person currently a patient in our office? ❑ Yes ❑ No

Insurance Information

Name of insured ______________________ Relationship to patient ____________

Birthdate ____________ SS #/SIN ____________ Date employed ____________

Name of employer ______________________ Work phone ____________

Address of employer ______________________ City ____________ State ______ Zip ____________

Insurance company ______________________ Group # ____________ Union of local # ____________

Ins. Co. address ______________________ City ____________ State ______ Zip ____________

How much is your deductible? ________ How much have you used? ________ Max. annual benefit? ________

Do you have any additional insurance? ❑ Yes ❑ No **If yes, complete the following:**

Name of insured ______________________ Relationship to patient ____________

Birthdate ____________ SS #/SIN ____________ Date employed ____________

Name of employer ______________________ Work phone ____________

Address of employer ______________________ City ____________ State ______ Zip ____________

Insurance company ______________________ Group # ____________ Union of local # ____________

Ins. Co. address ______________________ City ____________ State ______ Zip ____________

How much is your deductible? ________ How much have you used? ________ Max. annual benefit? ________

X ______________________________

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

◀ SIGNATURE

Patient Dental History

Have you noticed or had concerns:

Chronic bad breath	Y N	Upsetting dental experience	Y N
Bleeding/tender gums	Y N	Clenching/grinding teeth	Y N
Loose/shifting teeth	Y N	Sensitivity to cold/hot temperatures	Y N
Gum disease	Y N	Sensitivity to sweet/acidic foods	Y N
Dry mouth	Y N	Sensitivity to pressure/chewing	Y N
Food collecting between teeth	Y N	Jaw problems	Y N
Blisters/sores in mouth	Y N	Burning tongue	Y N

Do you have any dental concern/condition not listed?
____
____
____
____
____

Do you have a history of dental decay? Y N Do you have family history of gum disease? Y N

Do you use any form of tobacco? Y N Type__________________Amount per day ____________

Do you drink carbonated beverages? Y N Type__________________Amount per day ____________
(sport/energy drinks/soda pop/etc)

Patient Medical History

Preferred pharmacy______________________ Location____________________

Do you have:

Mitral Valve Prolapse	Y N	Thyroid problems	Y N	Fibromyalgia	Y N
Artificial heart valves	Y N	Cancer	Y N	Anemia	Y N
Pacemaker	Y N	treatment______________		Autoimmune disease	Y N
Heart attack	Y N	Seizures	Y N	______________________	
Low/High blood pressure?	Y N	Asthma	Y N	Chronic sinus trouble	Y N
Stroke	Y N	Kidney disease	Y N	Headaches (frequent)	Y N
Other heart problems	Y N	Hepatitis Type______	Y N	Liver disease	Y N
______________________		Herpes oral	Y N		
Artificial joint	Y N	Acid reflux	Y N		
Diabetes	Y N	AIDS/HIV	Y N		
Insulin dependent?	Y N	Alcoholism	Y N		
Osteoporosis (thinning bones)	Y N	Drug Addiction	Y N		
Emphysema	Y N	Ulcers	Y N		
Tuberculosis	Y N	Radiation Therapy	Y N		

Do you have any disease, condition or problem not listed above you think we should know about?______________
____
____
____

Women: Are you pregnant? Y N
Due date__________
Taking birth control? Y N
Are you nursing? Y N

Allergies:
- ❑ None
- ❑ Penicillin
- ❑ Sulfa
- ❑ Aspirin/Ibuprofen
- ❑ Codeine
- ❑ Clindamycin
- ❑ Latex
- ❑ Amoxicillin
- ❑ Percocet
- ❑ Any metals
- ❑ Vicodin
- ❑ Other__________
____
____

Surgeries/hospitalizations within the last 5 years (please list)
____
____

Medications: List any prescription, over-the-counter medications or supplements you are taking:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

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 hereby grant permission to Dr. Tennison for the administration of such medications and anesthetics and the performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care. I authorize and request my insurance company to pay directly to Dr. Tennison. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on my dependent(s) at the time of service.

Signature ______________________________________ Date ______________________
(Patient/Parent/Guardian)