ADVANCED DENTAL ASSOCIATES

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PATIENT INFORMATION:

Date: _____

Name: _____ **Preferred Name:** _____
Last First Initial

Birthdate: _____ **Soc. Sec #:** _____

Address:

_____
Street City State Zip

Sex: M...□ F...□ Married…□ Single…□ Other…□ **Home Phone:** _____

Cell: _____ **Work:** _____ **E-Mail:** _____

Employer: _____ **Preferred method of contact:** _____

Insurance Name: _____ **Ph #:** _____ **Group #:** _____

Subscriber Name: _____ **ID #:** _____ **Birthdate:** _____

Who should we thank for referring you? Insurance…☐ Location…☐ Internet website: _____
Co-Worker: _____ **Friend/Family:** _____ **Dr's office**_____

In the event of an emergency, who should we contact? Name: _____

Relationship: _____ **Best number to contact:** _____

How often do you brush? _____ **How often do you floss?** _____
Please check all that apply:

□ Bad Breath	□ Grinding Teeth	□ Sensitivity to Hot
□ Bleeding Gums	□ Loose Teeth	□ Sensitivity to Sweets
□ Blisters on Lips/Mouth	□ Orthodontic Treatment	□ Sensitivity when Biting
□ Broken Fillings	□ Pain around Ear	□ Sensitivity to Cold
□Finger Nail Biting	□ Periodontal Treatment	□ Jaw, Head or Neck Injuries
□Frequent Headaches	□ Lip or Cheek Biting	□ Jaw Difficulty: Clicking / Pain

□ Other: _____

Is there a particular area bothering you today? _____
Are you currently or have you recently been under the care of a physician? □ YES □ NO
If so, then diagnosis or treatment: _____

Physicians Name: _____ **Phone #:**_____

Pharmacy Name: _____ **Phone #:**_____

□YES □NO AIDS/HIV
□YES □NO Anemia
□YES □NO Arthritis
□YES □NO Rheumatism
□YES □NO Artificial Heart Valves
□YES □NO Artificial Joints
□YES □NO Asthma
□YES □NO Back Problems
□YES □NO Bleeding abnormally with extractions or surgery
□YES □NO Blood Disease
□YES □NO Cancer
□YES □NO Chemical Dependency
□YES □NO Chemotherapy
□YES □NO Circulatory Problems
□YES □NO Congenital Heart Lesions
□YES □NO Cortisone Treatments
□YES □NO Cough, Persistent or Bloody
□YES □NO Diabetes
□YES □NO Emphysema
□YES □NO Epilepsy
□YES □NO Fainting or Dizziness
□YES □NO Glaucoma
□YES □NO Headaches
□YES □NO Heart Murmur
□YES □NO Heart Problems

□YES □NO Hepatitis Type: _____
□YES □NO High Blood Pressure
□YES □NO Are you Pregnant
Due Date: _____
□YES □NO Do you smoke?
□YES □NO Jaundice
□YES □NO Jaw Pain
□YES □NO Kidney Disease
□YES □NO Liver Disease
□YES □NO Low Blood Pressure
□YES □NO Mitral Valve Prolapse
□YES □NO Nervous Problems
□YES □NO Pacemaker
□YES □NO Psychiatric Care
□YES □NO Radiation Treatment
□YES □NO Rheumatic Fever
□YES □NO Scarlet Fever
□YES □NO Shortness of Breath
□YES □NO Sinus Trouble
□YES □NO Skin Rash
□YES □NO Snore
□YES □NO Special Diet
□YES □NO Stroke
□YES □NO Swollen Feet or Ankles
□YES □NO Swollen Neck Glands
□YES □NO Thyroid Problems
□YES □NO Tonsillitis

□YES □NO Tuberculosis
□YES □NO Tumor/Growth on Neck/Head
□YES □NO Ulcer
□YES □NO Venereal Disease
□YES □NO Weight Loss, Unexplained
□YES □NO Auto Immune Disease
If YES, What? _____

□YES □NO Treated for Osteoporosis
If YES, with what? _____

Please list any surgeries in the past 5 years:

_____
_____
_____
_____
_____

Reviewed by
Assistant / Hygiene: _____

Doctor: _____

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____
_____
_____
_____
_____

ALLERGIES

□…Aspirin □…Barbiturates (sleeping pills) □…Codeine □…Iodine □…Latex

□…Local Anesthetic □…Penicillin □…Sulfa □…Other_____

PATIENT'S SIGNATURE: _____ **DATE:** _____

DOCTOR'S SIGNATURE: _____ **DATE:** _____

OFFICE USE:

Additional Notes:

_____
_____
_____
_____