

Spees Family Dentistry, PC

Patient Information

Name _____ **Birth Date** _____ **Social Security #** _____

Address _____ **How long** _____

City _____ **State** _____ **Zip** _____

Previous Address _____

Telephone numbers; Home _____ **Work** _____

Mobile _____ (Please check best number to reach you.)

E-Mail Address _____

(Would you like hygiene appointments confirmed by e-mail?) ____yes ____no

Employer _____ **How long** _____ **Position** _____

Address _____ **Telephone #** _____

City _____ **State** _____ **Zip** _____

May we contact you at work? Yes No

Spouse _____ **Birth Date** _____ **Social Security #** _____

Employer _____ **How long** _____ **Position** _____

Address _____ **Telephone #** _____

City _____ **State** _____ **Zip** _____

Dependents \ Children (names) _____

Nearest relative not living with you _____

Relationship _____ **Telephone #** _____

Insurance Company _____ **Group Number** _____

ID # _____ **Customer Service phone #** _____

Address for mailing claims: _____

Who is the insurance through? _____ **Their Social Security #** _____

PLEASE ANSWER EACH QUESTION

Are you allergic to any medications or latex? Yes No
 If so, what _____
 Have you ever had any excessive bleeding that required treatment? Yes No
 Have you ever had any difficulty during anesthesia? Yes No
 Women: Is there any chance you may be pregnant? Yes No
 Are you currently nursing? Yes No
 Have you been under the care of a physician during the last two years? Yes No

Physician's name _____

Reason: _____

Have you taken any medications during the past two years? Yes No

Reason & Name: _____

Are you taking any medications or supplements now? Yes No

If so, what & why? _____

Have you been a patient in the hospital? Yes No

Date & reason: _____

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

If so, how much do you use each day? _____

Heart trouble
 High blood pressure
 Low blood pressure
 Heart lesion
 Rheumatic fever
 Heart murmur
 Mitral valve prolapse
 Damaged heart valve
 Artificial heart valve
 Cardiac pacemaker
 Angina
 Chest pain

Abnormal bleeding
 Jaundice
 Hepatitis
 AIDS
 ARC
 Autoimmune disease
 Diabetes
 Venereal disease
 Herpes
 Chicken pox
 Measles
 Sinus trouble

Tuberculosis
 Cough
 Asthma
 Emphysema
 COPD
 Stroke
 Cancer
 Radiation/Chemotherapy
 treatment
 Mental health disorder
 Osteoporosis
 Joint replacement

Check any of the following that you have had:

Other _____

How many times do you brush _____ floss _____ day?

Do your gums ever bleed?

Yes No

Have you ever been treated for gum disease?

Yes No

Is your mouth dry?

Yes No

Do you ever grind your teeth? Yes No Day Night

Have you ever had problems with your jaw joint or TMJ?

Yes No

Do your teeth feel like they meet together unevenly?

Yes No

Do you have any clicking, popping, or discomfort in your jaw joint?

Yes No

How often do you get headaches? _____

Do you have any difficulty chewing or eating

Yes No

Has your jaw ever gotten stuck, locked or gone out?

Yes No

Have you ever had any injuries to your face, head, or neck?

Yes No

Do your teeth hurt or feel sore when you bite on them?

Yes No

Does hot, cold or sweets cause your teeth to hurt?

Yes No

Have you ever had a cold sore or cancer sore?

Yes No

Do you have any lump, bumps, or sores in your mouth now?

Yes No

Have you ever had any trouble with previous dental treatment such as, dizziness, fainting, or a reaction to dental anesthetic?

Yes No

Approximate date of your last dental visit? _____

Reason for your last dental visit? _____

Why are you here today? _____

Patient signature _____ **Date** _____