



## Patient Information Form

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available.  
If you have any questions, please do not hesitate to call us at: (719)992-2016.

### Patient Information

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
*Last First M.I.*

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*  
\_\_\_\_\_  
*City State ZIP Code*

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Sex  M  F  
Marital Status:  Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years

Employer/School: \_\_\_\_\_ Employer/School Phone: \_\_\_\_\_

Employer/School Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse or Parent's Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Person to contact in case of an emergency \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

### Responsible Party

Name of Person Responsible for this Account: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

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

Currently a patient in our office?  YES  NO Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### Insurance Information

Name of Insured: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Date Employed: \_\_\_\_\_

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

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ Union or Local #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used?: \_\_\_\_\_ Max Annual Benefit \_\_\_\_\_

### Additional Insurance

Name of Insured: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Date Employed: \_\_\_\_\_

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

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ Union or Local #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used?: \_\_\_\_\_ Max Annual Benefit: \_\_\_\_\_

### Dental History

Reason for today's visit: \_\_\_\_\_ Date of last dental care: \_\_\_\_\_

Former Dentist: \_\_\_\_\_ Date of last dental X-rays: \_\_\_\_\_

Address: \_\_\_\_\_

Check (✓) if you have or have had any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad Breath                        | <input type="checkbox"/> Grinding Teeth                 | <input type="checkbox"/> Sensitivity to hot             |
| <input type="checkbox"/> Bleeding Gums                     | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw           | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between the teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss?: \_\_\_\_\_ How often do you brush?: \_\_\_\_\_

**Medical History**

Physician's Name: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). YES NO

Have you ever had any serious illnesses or operations? YES NO  
  If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion? YES NO  
  If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant? YES NO Nursing? YES NO Taking birth control pills? YES NO

Check (✓) if you have or have had any of the following:

- Anemia
- Arthritis, Rheumatism
- Artificial Heart Valves
- Artificial Joints, Pins, etc.
- Asthma
- Back Problems
- Bleeding Abnormally
- Blood Disease
- Cancer
- Chemical Dependency
- Chemotherapy
- Circulatory Problems
- Congenital Heart Lesions
- Cortisone Treatments
- Cough, Persistent
- Cough up Blood
- Diabetes
- Epilepsy
- Fainting
- Glaucoma
- Headaches
- Heart Murmur
- Heart Problems
- Hemophilia
- Hepatitis
- Hernia Repair
- High Blood Pressure
- HIV/AIDS
- Jaw Pain
- Kidney Disease
- Liver Disease
- Mitral Valve Prolapse
- Pacemaker
- Radiation Treatment
- Respiratory Disease
- Rheumatic Fever
- Scarlet Fever
- Shortness Breath
- Skin Rash
- Stroke
- Swelling of Feet or Ankles
- Thyroid Problems
- Tobacco Habit
- Tonsillitis
- Tuberculosis
- Ulcer
- Venereal Disease

List medications you are currently taking and the correlating diagnosis: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Authorization & Release**

*I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold the dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.*

*I consent for the examination, teeth cleaning, application of topical fluoride, and necessary x-rays, and clinical photographs and any necessary sealants.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_