Manuelian Family Dental

Patient Information

Date _____ (MM/DD/YYYY) Home Ph# _____ Cell Ph# _____

Name _____ (Last / First / Middle Initial) SS/HIC/Patient ID# _____

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ Male ☐ Female Age _____ Birthdate _____ (MM/DD/YYYY)

☐ Married ☐ Single ☐ Widowed ☐ Minor ☐ Separated ☐ Divorced Partner of ____ Years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Ph# _____

City _____ State _____ Zip _____

Whom may we thank for referring you? _____

Emergency contact name _____ Ph# _____

Primary Insurance

Primary Account Holder _____ (Last / First / Middle Initial)

Relation to Patient _____ Birthdate _____ (MM/DD/YYYY) SS# _____

Address (if different from above) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Ph# _____

Insureance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependants covered by this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ (MM/DD/YYYY) Relation to Patient _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Ph# _____

Insurance Company _____ SS# _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependants covered by this plan _____

Manuelian Family Dental

Name _____ Gender _____ Age _____

Appointment Date _____ MM/DD/YYYY

Reason for Visit

What brings you to the office today?

_____

_____

_____

Current Medications

Are you currently taking any blood thinners? Yes ☐ No ☐

What medications are you currently taking?

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Dental History

When was your last dental exam? _____ MM/DD/YYYY

When were your last dental x-rays taken? _____ MM/DD/YYYY

How often do you brush? # times /day _____

How often do you floss? # times /day _____

Do you grind your teeth?
Yes ☐ No ☐

Have you ever had orthodontic (braces) treatment?
Yes ☐ No ☐

Have you ever had periodontal (gum) treatments?
Yes ☐ No ☐

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin
☐ Iodine ☐ Codeine ☐ Sulfa
☐ Local Anesthetics

Do you have any other allergies?

Name _____ Reaction _____

Name _____ Reaction _____

Hospitalizations & Surgeries

Reason _____ MM/DD/YYYY

Reason _____ MM/DD/YYYY

Reason _____ MM/DD/YYYY

Do you have any of the following?

☐ Bad Breath
☐ Bleeding Gums
☐ Blisters on Mouth
☐ Broken Fillings
☐ Diiculty Opening or Closing
☐ Diiculty Chewing
☐ Sensitivity to Heat
☐ Sensitivity to Sweets
☐ Sensitivity to Cold
☐ Sensitivity to Pressure
☐ Jaw Pain
☐ Loose Teeth
☐ Mouth Pain
☐ Mouth Sores
☐ Partials
☐ Ear Pain
☐ Dry Mouth
☐ Dentures
☐ Clicking Jaw
☐ Swollen Gums

Manuelian Family Dental

Past Medical History

Have you ever had any of the following?

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ AIDS / HIV
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bowel Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ Heart Problems
- ☐ Hepatitis - A, B, or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Joint Disorder Osteoporosis
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Lupus
- ☐ Measles
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Sinus problems
- ☐ Skin Disorder
- ☐ Stroke
- ☐ Stomach Ulcer
- ☐ Substance Abuse
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Venereal Disease

Lifestyle Factors

Have you ever smoked? Yes ☐ No ☐

# of years _____ # packs/day _____

Do you smoke now? Yes ☐ No ☐

packs/day _____

Do you use recreational drugs? Yes ☐ No ☐

Types _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much cafeine do you drink per day?

drinks/week _____

Women Only

Are you pregnant?

Yes ☐ No ☐

Are you breastfeeding?

Yes ☐ No ☐

What is your method of birth control?

_____

_____

_____