LAST NAME	FIRST NAME	MI	DATE OF BIRTH	RESIDENCE TEL	RESIDENCE ADDRESS	CITY	STATE	ZIP CODE

PERSON RESPONSIBLE FOR ACCT/ADDRESS	DENTAL INSURANCE	NAME OF INSURED PERSON/SOC SEC #	GROUP #	DATE OF BIRTH

INSURED PERSON'S EMPLOYER	BUSINESS TEL	BUSINESS ADDRESS	CITY	STATE	ZIP CODE

MEDICAL / DENTAL INFORMATION

DATE	CHIEF ORAL COMPLAINT

DATE OF LAST DENTAL EXAM		PREVIOUS DENTIST'S NAME

ADDRESS	PHONE

YES	NO		YES	NO	
☐	☐	Are you under a physician's care?	☐	☐	Have you tested HIV Positive?
☐	☐	Are you subject to prolonged bleeding?	☐	☐	Have you had a blood transfusion?
☐	☐	Are you taking medication now?	☐	☐	Are you pregnant? What month? _____
		List _____	☐	☐	Have you had any trouble with previous dental treatment?

Circle any of the following to which you are allergic or have had an unusual reaction:

Penicillin	Sulfa drugs	Codeine	Epinephrine	Iodine	Local Anesthetics
Erythromycin	Aspirin	Narcotics	Fluoride	Latex	Nitrous Oxide

Other: _____

Circle any of the following which you have or have had in the past:

High Blood Pressure	Venereal Disease	TMJ	Immunological Disorder
Congenital Heart Defect	Frequent Cold Sores	Epilepsy	Kidney Disease
Prolapsed Mitral Valve	Anemia	Jaundice	Steroid Therapy
Heart Murmur	Implants	Tuberculosis	Blood Disorder
Heart Trouble	Joint Replacement	Hepatitis	Leukemia
Pacemaker	Arthritis	Diabetes	Respiratory Disease
Stroke	Asthma	Radiation Treatment	AIDS
Rheumatic Heart Disease	Glaucoma	Psychiatric Treatment	Fainting Spells

Other: _____

FAMILY PHYSICIAN _____

ADDRESS	PHONE

X _____	DATE
SIGNATURE (Parent / Guardian if minor)	

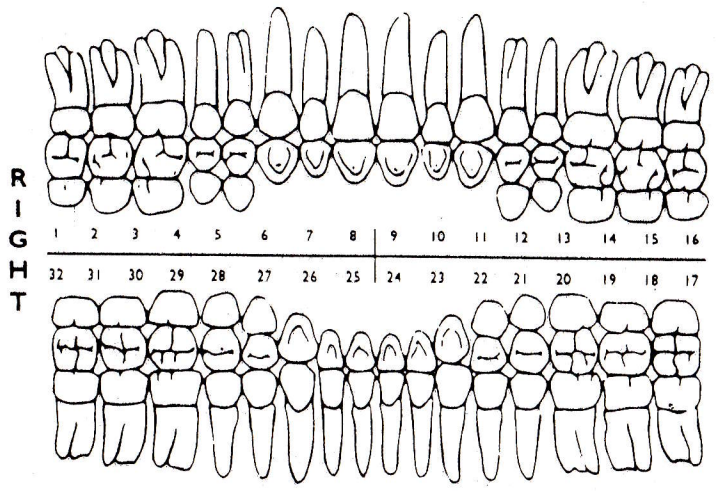
X _____	DATE
DENTIST SIGNATURE	

DATE REVIEWED

PIF-11/98

OFFICE USE ONLY

MISSING TEETH, EXISTING RESTORATIONS, CAVITIES, ABNORMALITIES



ORAL HEALTH

RECALL 3MTH ☐ 4MTH ☐ 6MTH ☐ 1YEAR ☐

X-Ray History _____

Referral History _____