Dr. William Moore
General Dentistry

PATIENT INFORMATION

Date					
Name		Home Phone			
Street Address		Cell Phone			
City		State		Zip	
Date of Birth		SSN		Gender	
Email					
Emergency Contact Name		Phone			
How did you hear about us?					

INSURANCE INFORMATION

Do you have dental insurance?	☐ Yes	☐ No	Insurance Name		
ID #		Group #			
Subscriber's Name		Subscriber's DOB			
Subscriber's Workplace					
Subscriber's SSN		Subscriber's Relationship			

RESPONSIBLE PARTY

Grantor's Name		Phone			
Street Address					
City		State		Zip	
Patient Relation to Guarantor		Guarantor Employer			
Street Address					
City		State		Zip	
Guarantor SSN		Guarantor DOB			

DENTAL HISTORY

1. What is your biggest concern about your dental health (if any)?		
2. What was your last visit to your family dentist and what was the nature of the treatment?		
3. Have you had periodontal treatment before?	☐ No	☐ Yes, When & Were?
4. How often and when is the last time your teeth were cleaned?		
5. Approximately when were your last dental x-rays?		

Check the following conditions if they apply to you

☐ swollen or bleeding gums	☐ bad tastes	☐ Sensitivity to hot, cold, or sweets	☐ painful gums or teeth	☐ bad breath mouth odors
☐ clenching or grinding of your teeth	☐ loose teeth	☐ increasing space between teeth	☐ other	

IMPORTANT: Have you ever been treated for **Osteoporosis or Osteopenia**? If yes, please check:

☐ ACTONEL	☐ FOSAMAX	☐ BONIVA	☐ ZOMETA	☐ SKELID	☐ OSTAC	☐ BONEFOS	☐ DIDRONEL

Physician		Last Seen / Reason	

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MEDICAL HISTORY

Please check in the YES or NO boxes	YES	NO
1. Are you allergic to any medications? If yes, what? _____	☐	☐
2. Have you had any serious illness, operations, or hospitalization in the past? Reason: _____	☐	☐
3. Has there been a change in your health in the last 2 years? _____	☐	☐
4. Are you a "bleeder: or have you had excessive bleeding following a dental treatment?	☐	☐
5. Are you presently under the care of a physician? If so, why? _____	☐	☐
6. Do you smoke or use tobacco products? How much? _____ How long? _____	☐	☐
7. Do you drink alcoholic beverages?	☐	☐
8. Have you had Cancer? Please describe. _____	☐	☐
9. Do you have any artificial joints? When & Type _____	☐	☐
10. Have you ever been diagnosed with obstructive sleep apnea?	☐	☐

11. HAVE YOU HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO			NO
High Blood Pressure	☐	☐	Angina	☐	☐	AIDS or H.I.V	☐	☐
Heart Murmurs	☐	☐	Heart Attack	☐	☐	Blood Disorders	☐	☐
Prolapsed Mitral Valve	☐	☐	Pacemaker	☐	☐	Nervous Disorders	☐	☐
Rheumatic Fever	☐	☐	Emphysema	☐	☐	Epilepsy/Seizures	☐	☐
Heart Problems	☐	☐	Asthma	☐	☐	Steroids Last 2 Years	☐	☐
Heart Bypass Surgery	☐	☐	Dialysis	☐	☐	Radiation / Chemo	☐	☐
Kidney Disease	☐	☐	Tuberculosis	☐	☐	Bleeding Problems	☐	☐
Chemical Dependency Treatment	☐	☐	Stroke	☐	☐			
Hepatitis / Liver Disease	☐	☐	Diabetes	☐	☐	**WOMEN ONLY**		
Oral Surgery Complications	☐	☐	Arthritis	☐	☐	Pregnant	☐	☐
Thyroid Disorders	☐	☐	Headaches	☐	☐	Breast Feeding	☐	☐

11. List **ANY** drugs or medicines that you are currently taking ☐ Check box if providing a medication list today

DRUG	DOSAGE / HOW OFTEN	HOW LONG	PRESCRIBER

Preferred Pharmacy		Location	
PATIENT SIGNATURE		DATE	

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