Main Street Dental
We are on your side!

PATIENT INFORMATION FORM

Today's Date ____ /____ /____

PATIENT INFORMATION

Please print and fill out as much information as possible.

Name _____ SS# _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Where and when are the best times to reach you? _____

Date of Birth ____ /____ /____ Age ____ Sex ____ Marital Status _____

Employer _____ Work Phone _____

Employer Address _____

PARENT / RESPONSIBLE PARTY

Please fill out this section if you are not the patient.

Name _____ SS# _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

INSURANCE INFORMATION / POLICY HOLDER

PRIMARY INSURANCE _____

Subscriber ID# _____ Group # _____

Name of Cardholder _____ Date of Birth ____ /____ /____ SS # _____

SECONDARY INSURANCE _____

Subscriber ID# _____ Group # _____

Name of Cardholder _____ Date of Birth ____ /____ /____ SS # _____

ADDITIONAL INFORMATION

Emergency Contact Name _____

Relationship to Patient _____ Phone _____

How did you hear about Main Street Dental? ❑ Ad ❑ Internet ❑ Drive by ❑ Family or Friend ❑ Insurance

If referred by family or friend, who may we thank? _____

Other family members seen by us? _____

DENTAL HISTORY

Who is your current or previous Dentist? _____ Date of Last Dental Visit ____ /____ /____

Why have you come to the Dentist today? _____

_____

Are you currently in pain? ❑ Yes ❑ No

How is your current dental health? ❑ Good ❑ Fair ❑ Poor

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No

Have you ever had gum treatment? ❑ Yes ❑ No

Do you now or have you ever experienced pain/ discomfort in you jaw joint (TMJ/TMD)?

Do you like your smile? ❑ Yes ❑ No

How many times a week do you floss? _____ How many times a day do you brush? _____

Type of bristles? ❑ Soft ❑ Medium ❑ Hard

How long do you use a toothbrush before replacing it? _____

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? ❑ Yes ❑ No If yes, why? _____

MEDICAL HISTORY

How is your current physical health? ❑ Good ❑ Fair ❑ Poor

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

Have you had any metal rods, pins, or implants? ❑ Yes ❑ No

Are you taking any prescriptions/over the counter or herbal supplemental drugs? ❑ Yes ❑ No

If so, please list each one: _____

_____

Have you ever taken Fosamax, or any other Bisphosphonate? ❑ Yes ❑ No

Have you ever taken Phen-Fen? ❑ Yes ❑ No

ALLERGIES

Are you allergic to any of the following?

❑ Aspirin
❑ Codeine
❑ Dental Anesthetics
❑ Erythromycin
❑ Latex
❑ Penicillin
❑ Tetracycline
❑ Other

Please list any other drugs/materials that you are allergic to: _____

_____

MEDICAL CONDITIONS

Have you ever had any of the following diseases or medical problems?

- ❑ Abnormal Bleeding
- ❑ Alcohol/Drug Abuse
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Bones/Joints/Valves
- ❑ Asthma
- ❑ Blood Transfusion
- ❑ Cancer/Chemotherapy
- ❑ Colitis
- ❑ Congenital Heart Defect
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting Spells
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ Herpes/Fever Blisters
- ❑ High Blood Pressure
- ❑ HIV+ /AIDS
- ❑ Hospitalized for Any Reason
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lupus
- ❑ Mitral Valve Prolapse
- ❑ Osteoporosis/Paget's Disease
- ❑ Pacemaker
- ❑ Psychiatric Problems
- ❑ Radiation Treatment
- ❑ Scarlet Fever
- ❑ Seizures
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis (TB)
- ❑ Ulcers
- ❑ Venereal Disease

Please list any other serious medical condition(s) that you have ever had: _____

_____

_____

FOR WOMEN

Are you using a prescribed method of birth control? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week# ____ Are you nursing? ❑ Yes ❑ No

SIGNATURE & ACKNOWLEDGEMENT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ Today's Date ____ /____ /____

Patient or Responsible Party Signature