

Today's Date _____

Name: _____ I prefer to be called: _____
Last First M.I.

Birthdate: ____/____/____ Age: _____ Social Security #: _____ Male/Female

Single Married Divorced Widowed Separated

Home Address: _____
Street City State Zip

Home Phone #: _____ Employer _____ Work Phone #: _____

Mobile/Cell #: _____ Receive e-mail confirmations? Yes ___ No ___

E-Mail Address: _____

When & Where are the best times to reach you? _____

Skip if responsible for self

Responsible Party Name: _____ Relationship: _____

Address: _____

Social Security # _____

Employer: _____ Work # _____

Employer's Address: _____

Spouse's Name: _____ SS#: _____

Whom may we thank for referring you? _____

Emergency Contact Person

His/Her Name: _____ Relation: _____ Home Phone #: _____

Address: _____ Work Phone #: _____
Street/P.O. Box City State Zip

Insurance Information

Company Name: _____ Phone #: _____ Group # _____

Insured Name: _____ SS#: _____ Birthdate: _____

Medical History

Do you have a personal physician? Yes/No

Physician's Name: _____ Office Phone: _____ Date of Last Visit: _____

Do you use tobacco? _____ Do you use controlled substances? _____ Do you wear contacts? _____

Women Only:

Are you pregnant or think you may be pregnant? _____ Are you nursing? _____

Are you taking oral contraceptives? _____

Are you allergic to any of the following?

- | | | | |
|-------------------------------------|---|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Sedatives | <input type="checkbox"/> Barbiturates |
| <input type="checkbox"/> Jewelry | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Codeine | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Any Metals | <input type="checkbox"/> Other _____ | | |

Please list all medications including over-the-counter, prescription, and herbal remedies that you are taking:

Do you have or have you experienced the following?

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Artificial Valves | <input type="checkbox"/> Allergies | <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Seizures | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Kidney Disease | | |

Please list any serious medical condition(s) you have experienced: _____

Dental History

- | | |
|---|---|
| <input type="checkbox"/> Gums bleed while brushing or flossing | <input type="checkbox"/> Teeth sensitive to hot or cold liquid/foods |
| <input type="checkbox"/> Feel pain to any of your teeth | <input type="checkbox"/> Teeth sensitive to sweet or sour liquids/foods |
| <input type="checkbox"/> Head, neck or jaw injuries | <input type="checkbox"/> Clicking, difficult chewing, difficult opening/closing |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Clench or Grind your teeth |
| <input type="checkbox"/> Had a difficult extraction in the past | <input type="checkbox"/> Prolonged bleeding following an extraction |
| <input type="checkbox"/> Had any orthodontic treatment | <input type="checkbox"/> Wear denture or partials |
| <input type="checkbox"/> Have taken or been advised to take antibiotics before any dental treatment | |
| * Date of Last Dental Visit _____ | |
| * How often do you floss? _____ | |

Consent and Release Authorization

I have reviewed, or will review, my dental treatment plan. I authorize release of any information relating to this dental treatment. I understand that my dental insurance is a contract between myself, my employer, and my insurance company. I also understand that I am fully responsible for any/all fees for dental services performed by Edwin S. Porter, D.D.S., P.A. and fees are due and payable in full when dental services are rendered. The insurance company will pay dental insurance benefits directly to me, the patient/policy holder.

X _____
Signature of patient

X _____
Signature of Dr. Edwin S. Porter