IDEAL FAMILY DENTAL

Name: _____ Preferred Name: _____
Last First Middle Initial

Address: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____ Birthdate: _____

Soc.Sec # _____ Phone Number: _____ Sex: Male Female

Married Single Partner Spouse's/ Partners Name _____

Person Responsible for Bill _____ Whom Referred you: _____

In case of an Emergency Contact

Full Name_____ Phone # _____

Relationship _____ Work Phone # _____

Insurance Information

Primary Insurance Co._____ SSI# or Subscriber ID#: _____

Subscriber Name: _____ Date of Birth: _____

Secondary Insurance Co. _____ SSI# Subscriber ID#: _____

Subscriber Name: _____ Date of Birth: _____

Dental History

When was your last dental visit? _____ Last X-rays (approximately)_____

Who was your previous dentist? Name: _____ Phone #: _____

Do you currently have any of the following? (Please check)

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of the mouth
- ☐ Cigarette pipe or cigar smoking
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Lip or cheek biting
- ☐ Loose or broken teeth
- ☐ Mouth breathing
- ☐ Mouth pain
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal Disease or Treatment
- ☐ Sensitivity to cold
- ☐ Sensitive to heat
- ☐ Sensitive to sweets
- ☐ Sensitive when biting
- ☐ Sores or growths in your mouth

Anything you would like to change about your smile: _____

_____

_____

Health History

Name Physician and/or Specialist you see and last date of visit: _____

_____

_____

List any medications you are currently taking and why: _____

_____

_____

Allergies: _____

_____

Please Circle any of the following in which you HAVE HAD OR CURRENTLY HAVE?

AIDS/ HIV
Anemia
Arthritis, Rheumatism
Artificial Heart Valves
Artificial Joints
Asthma
Auto Immune Disease
Back Problems
Bleeding abnormally with extraction or surgery
Blood Disease
Cancer
When: _____
Where: _____
Chemical Dependency
Chemotherapy
Congenital Heart Lesions
Cortisone Treatments
Cough
Diabetes Type: _____
Emphysema
Epilepsy
Fainting/Dizziness
Glaucoma
Headaches/ Migraines
Heart Murmur
Heart problems
Hepatitis Type _____
Herpes
High blood pressure
Jaundice
Jaw pain
Kidney Disease
Liver Disease
Low blood pressure
Mitral Valve prolapses
Nervous problems
Pacemaker
Premedication: _____
Psychiatric care
Radiation treatment
Respiratory disease
Rheumatic fever
Scarlet fever
Shortness of breath
Sinus Trouble
Special diet: _____
Stroke When: _____
Swollen feet
Thyroid Hypo or Hyper
Tonsillitis
Tuberculosis
Tumors
Ulcers
Smoking, Vaping, E-cigs, Chew less tobacco
Weight loss
Other: _____
_____
_____
_____

Women:
Are you Pregnant? Yes or No
Due Date: _____
Birth control? Yes or No
Are you Nursing? Yes or No

Any diseases, conditions or problems not listed? _____

_____

To the best of my knowledge, all preceding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform the dentist at the next appointment without fail. * I certify that I agree for Ideal Family Dental to bill my insurance company and I understand I am responsible for all charges weather or not paid by insurance.

_____ X_____ X_____

Date Patient Full Signature Dentist Signature