Connolly
FAMILY DENTISTRY

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ M____ Sex: ○ M ○ F

BIRTHDATE _____ AGE_____ Soc. Sec. #_____ Parent's/Guardian's Name _____

RESIDENCE Street _____ Apt. # _____ City _____ State_____ Zip_____

MAILING (If different from above) Street_____Apt. #_____ City_____ ST_____ Zip_____

HOME PHONE_____ CELL PHONE_____WORK PHONE_____

E-MAIL_____ I would like to receive text message appointment reminders ○ YES ○ NO

EMERGENCY CONTACT Name_____ Relationship_____ Contact #_____

Who May We Thank for Referring You To Our Office? _____Reason For This Visit _____

INSURANCE INFORMATION (PRIMARY)

POLICY HOLDER NAME Last _____ First _____ M_____ BIRTHDATE_____

Soc. Sec. #_____ (Most insurances require this for eligibility – Do **NOT** leave blank) OCCUPATION_____

Employer _____ Insurance Company_____

Insurance Company Address_____

Group #_____ Member ID #_____ (This could be Policy Holder's SS#) Local#_____

INSURANCE INFORMATION (SECONDARY)

POLICY HOLDER NAME Last _____ First _____ M_____ BIRTHDATE_____

Soc. Sec. #_____ (Most insurances require this for eligibility – Do **NOT** leave blank) OCCUPATION_____

Employer _____ Insurance Company_____

Insurance Company Address_____

Group #_____ Member ID #_____ (This could be Policy Holder's SS#) Local#_____

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Patient Medical History

Physician_____ Physician Address_____Physician Phone_____

Are you under a phsyicians care now? ___ Yes ___No If yes, please explain: _____

Are you taking any medications or prescriptions? ___Yes ___No Please list medicines:_____

_____

_____

Do you take or have you taken Fen-Phen/Redux? ___Yes ___No

Have you taken any medications containing bisphosphonates? ___Yes ___No

Do you use tobacco? (ie. Cigars, chew, and cigarettes) ___Yes ___No How long? _____

Women: Are you:

Pregnant/Trying to get pregnant? ___Yes ___No Taking oral Contraceptives? ___Yes ___No Nursing? ___Yes ___No

Are you ALLERGIC to any of the following?

___Aspirin ___Penicillin ___Codeine ___Local Anesthetics ___Acrylic ___Advil/NSAIDS

___ Metal ___Latex ___ Sulfa Drugs ___Erythromycin ___Nitrous Oxide

Other (please list):_____

Please indicate of the following which you have had or presently have:

AIDS/HIV Positive	YES	NO	Emphysema	YES	NO	Low Blood Pressure	YES	NO
Alzheimer's Disease	YES	NO	Epilepsy or Seizures	YES	NO	Lung Disease	YES	NO
Anaphylaxis	YES	NO	Fainting Spells/Dizziness	YES	NO	Mitral Valve Prolapse	YES	NO
Anemia	YES	NO	Frequent Headaches	YES	NO	Osteoporosis	YES	NO
Angina	YES	NO	Glaucoma	YES	NO	Psychiatric Care	YES	NO
Arthritis/Gout	YES	NO	Heart Attack/Failure	YES	NO	Radiation Treatments	YES	NO
Artificial Heart Valve	YES	NO	Heart Murmur	YES	NO	Reflux/G.E.R.D.	YES	NO
Artificial Joint	YES	NO	Heart Pacemaker	YES	NO	Respiratory Issues	YES	NO
Asthma	YES	NO	Heart Disease	YES	NO	Rheumatic/Scarlet Fever	YES	NO
Blood Disease	YES	NO	Hepatitis A	YES	NO	Shingles	YES	NO
Blood Transfusion	YES	NO	Hepatitis B or C	YES	NO	Shortness of Breath	YES	NO
Cancer	YES	NO	Hemophilia	YES	NO	Sickle Cell Disease	YES	NO
Chemotherapy	YES	NO	Herpes	YES	NO	Sinus Issues	YES	NO
Chest Pains	YES	NO	High Blood Pressure	YES	NO	Spina Bifida	YES	NO
Circulatory Problems	YES	NO	High Cholesterol	YES	NO	Stroke	YES	NO
Cold Sores/Fever Blisters	YES	NO	Irregular Heartbeat	YES	NO	Swelling of Limbs	YES	NO
Congenital Heart Disorder	YES	NO	Kidney Problems	YES	NO	Tonsillitis	YES	NO
Diabetes	YES	NO	Leukemia	YES	NO	Ulcer/Colitis	YES	NO
Drug Addiction	YES	NO	Liver Disease	YES	NO	Venereal Disease	YES	NO

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PATIENT DENTAL HISTORY

How long since you have seen a dentist? _____ Last cleaning?_____ Last Full Mouth X-Rays?_____

Are you having problems now, please explain?_____

Is your present dental health poor?	YES	NO	Are your teeth sensitive to sweets/sours?	YES	NO
Do you wear dentures?	YES	NO	Are your teeth sensitive to pressure?	YES	NO
Are you happy with your dentures?	YES	NO	Do you have headaches, earaches, or neck pains?	YES	NO
Would you like to know more about permanent replacements?	YES	NO	Do you have discolored teeth that bother you?	YES	NO
Have you had any periodontal (GUM) treatments?	YES	NO	Are you unhappy with the appearance of your teeth?	YES	NO
Do your gums bleed, feel tender, or irritated?	YES	NO	Have you worn braces on your teeth (orthodontics)?	YES	NO
Are you aware of grinding or clenching your teeth?	YES	NO	Would you like your smile to look better or different?	YES	NO
Are your teeth sensitive to hot/cold?	YES	NO	Do you regularly use dental floss?	YES	NO

Rate your level of anxiety from 1-5 (five being the highest): ____

Rate your level of concern for dental cost from 1-5 (five being the highest): _____

Do you have any other concerns or information you would like the doctor to be aware of?:_____

_____

_____

Patient Name Patient Signature Date