North Mesquite Dental Group
Date_____

Patient Information

First Name _____MI_____
Last Name_____
Name you go by_____
Hm Phone_____
Wk Phone_____
Cell Phone_____
Best Time and place to call_____
E-mail_____
Home address_____
_____#_____
City_____State____ Zip_____
Social Security # _____
Birthdate_____Age_____
□Married □Single □Minor □Divorced
□ Separated □ Widowed □ Partnered
Employer/School_____
Occupation_____
Spouse/Guardian Name_____
Employer_____
Occupation _____
Birthdate_____
SS# _____
Other Family Members seen by this office_____
_____
Who may we contact in case of an Emergency? _____
Phone # _____
Whom May we thank for referring you?
_____

Dental Insurance Information

Insurance Co._____
Insurance Phone #_____
Group #_____
Subscriber Name_____
Relationship to patient _____
Subscriber #_____
Subscriber SS#_____
Subscriber DOB_____
(Please provide Insurance card and ID)

Dental History

Reason for Today's Visit_____
Former Dentist_____
City/State_____
Phone #_____
Date of last Dental Visit_____
Date of Last Dental X-rays_____
Do you wear DENTURES? YES NO
If yes are you happy with them?YES NO
Have you had PERIODONTAL (gum) Treatments? YES NO
Do your gums BLEED, or feel TENDER, or IRRITATED? YES NO
Are you SENSITIVE to hot, cold, sweets, or pressure? YES NO
Cigarette, pipe, or cigar smoking? YES NO
Are you UNHAPPY with the appearance of your teeth? YES NO
Are you aware of GRINDING or CLENCHING you teeth? YES NO
Do you have HEADACHES, EARACHES, or NECK PAINS? YES NO
Do you have LOOSE, TIPPED or SHIFTING teeth? YES NO
Have you worn BRACES on your teeth? (ORTHODONTICS) YES NO
Do you have DISCOLORED teeth that bother you? YES NO
Do you have problems with teeth/fillings BREAKING? YES NO
Do you have SORES or GROWTHS in you mouth? YES NO
Do you REGULARLY use DENTAL FLOSS? YES NO
How OFTEN do you BRUSH? _____

Do you want Nitrous for Treatment? (Also known as laughing gas)
YES NO

Health History

Physician's Name_____ Phone # _____ Date of last Visit_____

Do you have CURRENT HEALTH PROBLEMS? YES NO

Are you under a PHYSICIANS care now? YES NO

If yes for what? _____

Please mark any of the following which you have had or have at present:

□ Heart attack
□ High blood pressure
□ Congenital Heart lesions
□ Heart pacemaker
□ Anemia
□ Ulcers
□ Hepatitis B (Serum)
□ Blood transfusion
□ Fever Blisters
□ Nervousness
□ Glaucoma
□ Tuberculosis (TB)
□ Sinus Trouble
□ Thyroid Disease
□ Rheumatism
□ Alcoholism
□ Bruise Easily
□ AIDS/HIV

Do you wear Contact Lenses? YES NO

List any medication you are currently taking and the diagnosis: _____

_____

_____

_____

_____

Pharmacy Name

_____

Phone #_____

Women

Are you Pregnant? Y N

Due Date? _____

Are you nursing? YES NO

Taking birth control pills? YES NO

□ Heart disease
□ Heart murmur
□ Scarlet fever
□ Heart surgery
□ Liver disease
□ Drug addiction
□ Epilepsy or seizures
□ Psychiatric treatment
□ Chemotherapy (cancer/ Leukemia)
□ Asthma
□ Allergies or hives
□ X-ray/ Cobalt treatment
□ Cortisone medication
□ Bleeding problems
□ Emphysema
□ Angina pectoris
□ Rheumatic fever
□ Artificial heart valve
□ Artificial joint/hip/knee

Drug Allergies

□ Aspirin
□ Codeine
□ Iodine
□ Latex
□ Local anesthetic
□ Penicillin
□ Sulfa

Other Please list

_____

_____

Have you ever been told you need to take Pre-Medication before dental visits? YES NO

□ Kidney trouble
□ Hepatitis Type____
□ Yellow jaundice
□ Hemophilia
□ Fainting or dizzy spells
□ Sickle cell disease
□ Venereal disease
□ Hay fever
□ Diabetes
□ Arthritis
□ Pain in jaw joints
□ Pneumonia
□ Take aspirin on a daily basis?

I understand and agree that **(regardless of my insurance status); I am ultimately responsible for the balance** of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to best of my knowledge. **I will notify you of any changes in my status of the above information.**

_____

Signature/Date (parent if Minor)

_____