ADVANCED DENTAL ASSOCIATES

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PATIENT INFORMATION: **Date:** _____

Name: _____ **Preferred Name:** _____
Last First Initial

Birthdate: _____ **Soc. Sec #:** _____

Address: _____
Street Apt # City State Zip

Sex: M...□ F...□ Married…□ Single…□ Other…□

Home Phone: _____ **Cell:** _____ **Work:** _____

E-Mail: _____ **Preferred method of contact:** _____

Employer: _____

Insurance Name: _____ **Ph #:** _____ **Group #:** _____

Subscriber Name: _____ **ID #:** _____ **Birthdate:** _____

Whom should we thank for referring you? Insurance…☐ Location…☐ Website…☐
Friend/Family: _____ Co-Worker: _____ Dr's office: _____

In the event of an emergency, who should we contact? Name: _____

Relationship: _____ **Best number to contact:** _____

How often do you brush? _____ **How often do you floss?** _____

Please check all that apply:

□ Bad Breath	□ Grinding Teeth	□ Sensitivity to Hot	□ Bleeding Gums
□ Loose Teeth	□ Sensitivity to Sweets	□ Blisters on Lips/Mouth	□ Lip or Cheek Biting
□ Broken Fillings	□ Pain around Ear	□ Orthodontic Treatment	□ Periodontal Treatment
□Finger Nail Biting	□ Sensitivity to Cold	□Frequent Headaches	□ Sensitivity when Biting
□ Jaw, Head or Neck Injuries		□ Jaw Difficulty: Clicking / Pain	

How can we help you today? _____

Smile Evaluation:

Do you like the way your teeth look? □YES □NO **Would you like your teeth to be straighter?** □YES □NO
Are you happy with the color? □YES □NO **Missing teeth you would like to replace?** □YES □NO
If you could change anything about the appearance of your smile, what would you change?

_____

_____

Please check YES or NO to indicate if you have had any of the following:

□YES □NO AIDS/HIV
□YES □NO Anemia
□YES □NO Arthritis
□YES □NO Rheumatism
□YES □NO Artificial Heart Valves
□YES □NO Artificial Joints
□YES □NO Asthma
□YES □NO Back Problems
□YES □NO bleeding abnormally with extractions or surgery
□YES □NO Blood Disease
□YES □NO Cancer
□YES □NO Chemical Dependency
□YES □NO Chemotherapy
□YES □NO Circulatory Problems
□YES □NO Congenital Heart Lesions
□YES □NO Cortisone Treatments
□YES □NO Cough, Persistent or Bloody
□YES □NO Diabetes
□YES □NO Emphysema
□YES □NO Epilepsy
□YES □NO Fainting or Dizziness
□YES □NO Glaucoma
□YES □NO Headaches
□YES □NO Heart Murmur
□YES □NO Heart Problems
□YES □NO Hepatitis Type: _____
□YES □NO High Blood Pressure
□YES □NO Are you Pregnant
Due Date: _____
□YES □NO Do you smoke?
□YES □NO Jaundice
□YES □NO Jaw Pain
□YES □NO Kidney Disease
□YES □NO Liver Disease
□YES □NO Low Blood Pressure
□YES □NO Mitral Valve Prolapse
□YES □NO Nervous Problems
□YES □NO Pacemaker
□YES □NO Psychiatric Care
□YES □NO Radiation Treatment
□YES □NO Rheumatic Fever
□YES □NO Scarlet Fever
□YES □NO Shortness of Breath
□YES □NO Sinus Trouble
□YES □NO Skin Rash
□YES □NO Snore
□YES □NO Special Diet
□YES □NO Stroke
□YES □NO Swollen Feet or Ankles
□YES □NO Swollen Neck Glands
□YES □NO Thyroid Problems
□YES □NO Tonsillitis
□YES □NO Tuberculosis
□YES □NO Tumor/Growth on Neck/Head
□YES □NO Ulcer
□YES □NO Venereal Disease
□YES □NO Weight Loss, Unexplained
□YES □NO Auto Immune Disease
If YES, What?
_____

□YES □NO Treated for Osteoporosis
If YES, with what?
_____

□YES □NO Tested positive for COVID-19
If YES, when? _____

Please list any surgeries in the past 5 years:
_____
_____
_____
_____
_____
_____

Reviewed by:
Assistant: _____

Doctor: _____

Are you currently or have you recently been under the care of a physician? □ YES □ NO
If so, then diagnosis or treatment: _____

Physicians Name: _____Phone #:_____

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____
_____
_____
_____
_____
_____

ALLERGIES

□…Aspirin □…Barbiturates (sleeping pills) □…Codeine □…Iodine □…Latex
□…Local Anesthetic □…Penicillin □…Sulfa □…Other_____

PATIENT'S SIGNATURE: _____ **DATE:** _____

DOCTOR'S SIGNATURE: _____ **DATE:** _____

OFFICE USE:

Additional Notes: