



# CONFIDENTIAL PATIENT INFORMATION

**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
First Middle Last

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Male**  **Female**  **School:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street City State Zip Code

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **E-Mail:** \_\_\_\_\_

**How did you hear about our office?** \_\_\_\_\_

## Confidential Responsible Party Information

**1. Name:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_  
First M. Initial Last

**Address:** \_\_\_\_\_  Rent  Own  
Street City State Zip Code

**How Long at this address?** \_\_\_\_ Years \_\_\_\_ Months **Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Previous Address (If less than 3 yrs):** \_\_\_\_\_  
Street City State Zip Code

**Social Security #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Marital Status:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_ **No. Years Employed** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_ **Group #:** \_\_\_\_\_ **Union Local #** \_\_\_\_\_

**Insurance Co. Address:** \_\_\_\_\_ **Insurance Co. Phone:** \_\_\_\_\_

**2. Name:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_  
First M. Initial Last

**Address:** \_\_\_\_\_  Rent  Own  
Street City State Zip Code

**How Long at this address?** \_\_\_\_ Years \_\_\_\_ Months **Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Previous Address (If less than 3 yrs):** \_\_\_\_\_  
Street City State Zip Code

**Social Security #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Marital Status:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_ **No. Years Employed** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_ **Group #:** \_\_\_\_\_ **Union Local #** \_\_\_\_\_

**Insurance Co. Address:** \_\_\_\_\_ **Insurance Co. Phone:** \_\_\_\_\_

## Dental History

General Dentist: \_\_\_\_\_ Address (City): \_\_\_\_\_

Date of last visit to the Dentist: \_\_\_\_\_ Date of last X-rays taken: \_\_\_\_\_

*Has the patient had, or have you noticed any of the following:*

- |   |   |
|---|---|
| <input type="checkbox"/> Teeth sensitive to hot, cold, sweets or pressure   | <input type="checkbox"/> Oral habits: <input type="checkbox"/> <i>Thumb sucking</i> |
| <input type="checkbox"/> Traumatic injury to teeth, mouth, or face  | <input type="checkbox"/> <i>Fingernail biting</i>                                   |
| <input type="checkbox"/> Pain or tenderness around ear, jaw joint, or side of face  | <input type="checkbox"/> <i>Cheek biting</i>  |
| <input type="checkbox"/> Difficulty in: <input type="checkbox"/> <i>Opening</i> <input type="checkbox"/> <i>Closing</i> <input type="checkbox"/> <i>Chewing</i> | <input type="checkbox"/> Clenching or grinding of teeth                             |
| <input type="checkbox"/> Clicking, locking, or popping of jaw joint   | <input type="checkbox"/> Loosening of your teeth                                    |
| <input type="checkbox"/> Tonsils or adenoids removed  | <input type="checkbox"/> Periodontal treatment                                      |
| <input type="checkbox"/> Mouth breathing  | <input type="checkbox"/> Missing Teeth  |

If you answered *yes* to any of the above, please explain: \_\_\_\_\_

Has patient ever had any orthodontic treatment?  Yes  No When? \_\_\_\_\_

## Medical History

Medical Physician: \_\_\_\_\_ / \_\_\_\_\_ Date of Last Medical Exam: \_\_\_\_\_  
Name City

List any Medications: \_\_\_\_\_ List any **serious** illnesses: \_\_\_\_\_

Is the patient in good health?  Yes  No

Is patient **allergic** to:  Penicillin  Codeine  Local anesthetic injections  **Other:** \_\_\_\_\_

*Has the patient ever been diagnosed or treated for any of the following:*

- | Yes                      | No                       | Yes                      | No                       | Yes                      | No                       |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I understand that credit bureau reports may be obtained. I read and understand English.

Signature of responsible party: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Dante A. Gonzales, D.M.D., M.S.D. Date  
John C. Huang, D.M.D., D.Med. Sc.