3397 N. 1200 E. Ste 102 • Lehi, UT 84043 • 801-541-9950

PATIENT INFORMATION

FIRST NAME	MI	LAST NAME	PREFERRED NAME	DATE

DATE OF BIRTH	GENDER ☐ M ☐ F	SSN	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER: ______

HOME PHONE	CELL PHONE	WORK PHONE	EXTENSION

EMAIL ADDRESS	COMMUNICATION PREFERENCE FOR CLINICAL INFORMATION (SELECT ONE) ☐ HOME PHONE ☐ CELL PHONE ☐ WORK PHONE ☐ EMAIL ☐ MAIL

HOME STREET ADDRESS	APARTMENT #	CITY	STATE	ZIP CODE

OCCUPATION	EMPLOYER	EMPLOYER PHONE

EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

NAME OF PERSON WHO REFERRED YOU TO US	OTHER REFERRAL SOURCE ☐ INSURANCE CO. ☐ MAILER ☐ DRIVE-BY ☐ WEBSITE ☐ OTHER:

RESPONSIBLE PARTY (DISREGARD IF SAME AS ABOVE)

FIRST NAME	MI	LAST NAME	RELATIONSHIP TO PATIENT

DATE OF BIRTH	GENDER ☐ M ☐ F	SSN	DRIVER'S LICENSE #	STATE

HOME PHONE	CELL PHONE	WORK PHONE	EXTENSION

EMAIL ADDRESS	PREFFERRED PHARMACY	PHARMACY PHONE

HOME STREET ADDRESS	APARTMENT #	CITY	STATE	ZIP CODE

OCCUPATION/POSITION	HOW LONG?	EMPLOYER	EMPLOYER PHONE

EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

PRIMARY INSURANCE ☐ INSURANCE CARD PROVIDED

SUBSCRIBER FIRST NAME	SUBSCRIBER LAST NAME
DATE OF BIRTH	PATIENT'S RELATIONSHIP TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ PARENT

INSURANCE COMPANY	INSURED'S SSN

INSURANCE COMPANY ADDRESS	STATE	ZIP CODE

EMPLOYER

GROUP #	POLICY #
GROUP NAME	POLICY EFFECTIVE DATE

SECONDARY INSURANCE ☐ INSURANCE CARD PROVIDED

SUBSCRIBER FIRST NAME	SUBSCRIBER LAST NAME
DATE OF BIRTH	PATIENT'S RELATIONSHIP TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ PARENT

INSURANCE COMPANY	INSURED'S SSN

INSURANCE COMPANY ADDRESS	STATE	ZIP CODE

EMPLOYER

GROUP #	POLICY #
GROUP NAME	POLICY EFFECTIVE DATE

I verify that the above information is true and correct.

Signature: ______________________________ *Date:* ____________________

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Patient Name: ______________________ Date of last dental visit: ______________

Reason for today's visit: ______________________________________

DENTAL HEALTH

Please check any of the following that apply to your mouth:

- ☐ Acid Reflux
- ☐ Antibiotic Premedication for dental tx
- ☐ Bad Breath
- ☐ Burning mouth/tongue
- ☐ Cankers
- ☐ Cold Sores
- ☐ Clench or Grind Teeth
- ☐ Dry Mouth
- ☐ Gums swollen, tender or bleeding
- ☐ Jaw pain
- ☐ Mouth Breathing
- ☐ Orthodontic Treatment
- ☐ Periodontal Treatment
- ☐ Sensitivity to Pressure
- ☐ Tobacco Use Type: ______________ Frequency: __________

How often do you brush? ______________ Floss? ______________

Have you ever had a reaction to dental anestheic? ☐ Yes ☐ No

Explain: ______________________________________

MEDICAL HISTORY

Allergies

- ☐ Yes ☐ No Aspirin
- ☐ Yes ☐ No Codeine/Narcotics
- ☐ Yes ☐ No Dental Anesthetic
- ☐ Yes ☐ No Iodine
- ☐ Yes ☐ No Latex
- ☐ Yes ☐ No Metals/Nickels/Jewelry
- ☐ Yes ☐ No Penicillin or Amoxicillin
- ☐ Yes ☐ No Sulfa Drugs
- ☐ Yes ☐ No Hay Fever/Seasonal Allergies

Other: ______________________

Cardiovascular Health

- ☐ Yes ☐ No Angina or Heart Attack
- ☐ Yes ☐ No Coronary Bypass
- ☐ Yes ☐ No Heart Disease or treatment
- ☐ Yes ☐ No Heart valve problem/replacement
- ☐ Yes ☐ No Heart Murmur
- ☐ Yes ☐ No Congenital Heart Murmur
- ☐ Yes ☐ No High Blood Pressure
- ☐ Yes ☐ No Irregular Heartbeat/Pacemaker
- ☐ Yes ☐ No Low Blood Pressure
- ☐ Yes ☐ No Past use of Phen-Fen
- ☐ Yes ☐ No Rheumatic Fever
- ☐ Yes ☐ No Stroke

Endocrine/Blood/Immune Health

- ☐ Yes ☐ No Abnormal Bleeding/Bruising
- ☐ Yes ☐ No Anemia
- ☐ Yes ☐ No Blood transfusion
- ☐ Yes ☐ No Cancer

Type: ______________________

- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Hemophilia
- ☐ Yes ☐ No HIV Infection/AIDS
- ☐ Yes ☐ No Lupus
- ☐ Yes ☐ No Organ transplant
- ☐ Yes ☐ No Rhuematoid Arthritis
- ☐ Yes ☐ No Thyroid Problems

GI/Urinary Health

- ☐ Yes ☐ No Crohn's Disease
- ☐ Yes ☐ No Hepatitis Type: ________
- ☐ Yes ☐ No Kidney disease/Dialysis
- ☐ Yes ☐ No Liver Disease
- ☐ Yes ☐ No Ulcers
- ☐ Yes ☐ No Ulcerative Colitis
- ☐ Yes ☐ No Sexually Transmitted Disease

Muscular-Skeleton/CNS/Mental Health

- ☐ Yes ☐ No Arthritis
- ☐ Yes ☐ No Anxiety/Nervousness
- ☐ Yes ☐ No Dementia/Alzheimer's
- ☐ Yes ☐ No Depression
- ☐ Yes ☐ No Epilepsy
- ☐ Yes ☐ No Fainting/Dizziness
- ☐ Yes ☐ No History of Alcohol or Drug Abuse
- ☐ Yes ☐ No Joint Replacement
- ☐ Yes ☐ No Mental Health Treatment
- ☐ Yes ☐ No Multiple Sclerosis
- ☐ Yes ☐ No Osteoporosis
- ☐ Yes ☐ No Schizophrenia
- ☐ Yes ☐ No Seizures

Repiratory Health

- ☐ Yes ☐ No Asthma
- ☐ Yes ☐ No COPD
- ☐ Yes ☐ No Chronic Sinus Problems
- ☐ Yes ☐ No Emphysema
- ☐ Yes ☐ No Tuberculosis

Are you currently under the care of a physician? ☐ Yes ☐ No

Name of Physician: ______________________________

Other medical conditions we should be aware of?: ______________________

List all medications you are currently taking

Medication: ______________ Condition: ______________

Medication: ______________ Condition: ______________

Medication: ______________ Condition: ______________

Medication: ______________ Condition: ______________

Women only:

Are you currently:

Nursing: ☐ Yes ☐ No

Pregnant: ☐ Yes ☐ No

Taking Birth control pills: ☐ Yes ☐ No

I have answered all health questions to the best of my knowledge.

Signature: ______________________ *Date:* ______________