GARDEN VALLEY
FAMILY & COSMETIC DENTISTRY

Patient Information

Full Name_____

Address _____

City _____ State _____ Zip _____

Patient or Parent's Employer _____

Employer's Address _____

City _____ State _____ Zip _____

If Pt Is A Student, Name of School _____

City _____ State _____

How did you hear about us? (please circle all that apply):

Family/Friends	Our website
Office sign	Google
Event	Online ad
Flyer/Coupon	Radio
Insurance plan	Facebook/Instagram
Other:	

Birthdate (MM/DD/YYYY)

_____

SS Number

_____

Cell Phone

_____

Work Phone

_____

Email

_____

Circle Appropriate Selection:

Minor Single Married

Divorced Widowed Separated

Do you have family or friends who may need dental care? If so, please provide their name and phone numbers or email addresses and we can contact them.

_____

_____

_____

_____

Responsible Party

Full Name Of Responsible Party For This Account

_____

Address _____

City _____ State _____ Zip _____

Employer _____

Employer Address _____

City _____ State _____ Zip _____

Relationship to Patient

_____

Home Phone _____

Work Phone _____

Cell Phone _____

Birthdate (MM/DD/YYYY)

_____

SS Number _____

Primary Insurance Information

Name of Insured _____

Insurance Company _____

Subscriber / Member ID _____

Insurance Address_____

City _____ State _____ Zip _____

Group Number _____ Group Name _____

Relationship to Patient

_____

Birthdate (MM/DD/YYYY)

_____

SS Number _____

Insurance Phone _____

Secondary Insurance Information

Name of Insured _____

Insurance Company _____

Subscriber / Member ID _____

Insurance Address_____

City _____ State _____ Zip _____

Group Number _____ Group Name _____

Relationship to Patient

_____

Birthdate (MM/DD/YYYY)

_____

SS Number _____

Insurance Phone _____

Medical History: (please check Yes or No column):	**Yes**	**No**	**Medical History:** (please check Yes or No column):	**Yes**	**No**
Are You Under the Care of a Physician?			Are You Taking Medications? Including Over the Counter and Prescription		
If yes, physician name and phone number:			Please list all medications: (if needed attach medication list)		
Date of last physical Exam:					
Do You Have Any Known Drug Allergies?					
If yes, please list below:			Have You Been Hospitalized in The Last Five Years?		
			Have You Ever Had A Reaction to Anesthetic?		
Do You Use Cocaine or Other Drugs?			Fainting/Seizures		
Do You Use Tobacco?			Swollen Ankles		
Do You Use Alcohol?			Blood Pressure Issue (circle one)	HIGH	LOW
Do You Wear Contacts?			Asthma		
Diabetes I			Heart Attack		
Diabetes II			Epilepsy/Convulsions		
Heart Disease			Leukemia		
Cardiac Pacemaker			Hay Fever/Allergies		
Heart Murmur			Tuberculosis		
Angina			Radiation Therapy		
Frequently Tired			Glaucoma		
Anemia			Liver Disease		
Emphysema			Kidney Disease		
Cancer			Aids/HIV Infection		
Arthritis			STD's		
Joint Replacement			Thyroid Problems		
Chest Pains			Hepatitis A, B or C		
Short of Breath			Ulcers		
Stroke			Respiratory Problems		
Rheumatic Fever			Stroke		
Other issues (please explain):			**Women Only:**		
			Are You Pregnant?		
			Are You Taking Birth Control Pills?		
			Are You Nursing?		

Dental History (please check Yes or No column):	**Yes**	**No**	**Dental History** (please check Yes or No column):	**Yes**	**No**
Do Your Gums Bleed While Brushing or Flossing?			Do You Have Pain in Your Jaw Joint, Ear or Side of The Face?		
Are Your Teeth Sensitive to Hot or Cold Liquids/Foods?			Do You Have Difficulty Opening or Closing Your Mouth?		
Are Your Teeth Sensitive to Sweet or Sour Liquids/Foods?			Do You Have Difficulty Chewing?		
Do You Feel Pain in Any of Your Teeth?			Do You Have Frequent Headaches?		
Do You Have Any Sores or Lumps in Your Mouth?			Do You Clench or Grind Your Teeth?		
Have You Ever Suffered Trauma to Your Face Mouth or Jaw?			Do You Bite Your Lips or Cheeks Frequently?		
Does Your Jaw Ever Click, Pop, Crackle or Ache?			Have You Had Problems with Previous Dental Work?		
How Often Do You Floss?			Have You Ever Had Braces?		
Do You Use A Manual Brush or Electric?			How Many Times A Day Do You Brush Your Teeth?		
Do You Use Any Type of Mouth Rinse?					
Do you have any Goals for your mouth, teeth, or smile? If so, what are they?					
If you could change anything about your smile, what would that be?					

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

Patient/Legal Guardian Signature: _____ Date: _____

Print name if signed on behalf of the patient: _____

Relationship to patient: _____

Dentist signature: _____ Date: _____

Witness signature: _____ Date: _____