Milford FAMILY Dentistry

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PLEASE FILL IN THE INFORMATION REQUESTED BELOW. DATE:_____

PATIENT'S NAME (PRINT): BIRTHDATE SSN: BEST PH #:

STREET ADDRESS CITY STATE ZIP EMAIL

PRESENT OCCUPATION (OF PARENTS IF CHILD PATIENT) EMPLOYER WORK PHONE

DENTAL INSURANCE CO. POLICY HOLDER SSN OR SUBSCRIBER/POLICY #:
☐ NONE

SECONDARY INSURANCE (IF APPLICABLE):

PERSON RESPONSIBLE FOR BILL: ADDRESS: PHONE #:

HOW DID YOU HEAR ABOUT OUR OFFICE? IF ANOTHER PATIENT, PLEASE PROVIDE THEIR NAME

CURRENT PHYSICIAN'S NAME ADDRESS PHONE #:

LIST ANY MEDICAL CONDITIONS OR TREATMENT IN THE LAST 12 MONTHS:

☐ NONE

LIST ANY DRUGS OR MEDICATIONS CURRENTLY BEING USED:
☐ NONE

LIST ANY KNOWN ALLERGIES TO DRUGS, MEDICATIONS, ETC:
☐ NONE

PLEASE CHECK ANY CONDITIONS BELOW WHICH YOU HAVE HAD:

☐ HEART DISEASE
☐ HEART MURMUR OR MVP
☐ HIGH BLOOD PRESSURE
☐ RHEUMATIC FEVER
☐ HEPATITIS
☐ TUBERCULOSIS
☐ DIZZINESS OR EPILEPSY
☐ STOMACH AILMENT
☐ CYSTS, TUMORS, OR GROWTH
☐ AIDS
☐ ARTIFICIAL JOINTS
☐ PREGNANT (AT PRESENT)
☐ BREATHING OR LUNG PROBLEM
☐ DIABETES
☐ KIDNEY OR LIVER PROBLEM
☐ NERVOUS OR MENTAL PROBLEM
☐ VENEREAL DISEASE
☐ RADIATION THERAPY
☐ BLOOD OR BLEEDING DISORDER
☐ ARTHRITIS
☐ NONE OF THE PRECEDING
☐ OTHER - PLEASE EXPLAIN MEDICAL CONDITIONS:

_____

_____

_____

IF YOU HAVE QUESTIONS OR CONCERNS ABOUT ANY OF THE FOLLOWING, PLEASE CHECK:

☐TOOTH SENSITIVITY
☐CAVITIES
☐WISDOM TEETH
☐ GUM PROBLEMS
☐ CROWNS (CAPS)
☐ BRIDGE WORK
☐ IMPLANTS
☐ PARTIAL DENTURES
☐ FULL DENTURES
☐ ROOT CANALS
☐ ORTHODONTICS
☐ INVISALIGN/CLEAR ALIGNERS
☐ BONDINGS
☐ SEALANTS
☐ JAW JOINT/TMJ
☐ FLOSSING
☐ BLEACHING/WHITENING
☐ MISSING TEETH
☐ SMILE ANALYSIS
☐ OTHER:_____