*Dr. Linkous and staff are glad you have chosen us as your dental health care team.*

*We are dedicated in providing you with the best dental care possible. In order to do this, we ask that you take a moment to complete this patient information form. It is important that* ***fl11.*** *questions be answered.* ***Please do not leave any blanks.*** *If you need assistance please ask. We will be happy to help.*

**PATIENT INFORMATION (CONFIDENTIAL)**

## Name- - - - - - - - - - - -

Birthdate- - - - - -

SS#- - - - - - Home Phone- - - - - - - -

### Address (No P.O. Boxes) City\_ \_

\_ \_ \_

\_ State\_

\_ \_Zip\_ \_

\_ \_ \_ \_

Martial Status (Please Circle) Married Single Minor Divorced Widowed

Patient's Ernpl oyer\_ \_

\_ \_ \_

\_ \_ \_ \_ \_

\_ \_ \_

\_ \_ \_

\_ \_ \_

\_ \_ Work Phone\_ \_ \_ \_

\_ \_ \_

\_ \_ \_

If Patient is a College Student, Name and City of College Full Time Part Time

Emergency Contact Narne- - - - - - - - - - - - - - - - - - -Phone-- - - - - - - - - - -

How Did Your Hear About Our Office?- - - - - - - - - - - - - - - - - - - - - - - - - - - -

# INSURANCE INFORMATION (DENTAL ONLY)

### Name of Insured\_ \_ \_

\_ \_ \_

\_ \_ \_

\_ \_ \_

\_ \_ \_

\_ \_ \_ Relationship to Patient\_ \_

\_ \_ \_

\_ \_ \_ \_ \_

Address (If different from Patient)\_ \_ \_

\_ \_ \_ \_ \_

\_ \_ \_

\_ \_ \_

\_ \_ \_

\_ \_ \_

\_ \_ \_

\_ \_ \_ \_ \_ \_

Birthdate\_ \_ \_ \_

\_ \_ \_

\_ \_ \_ SS#\_ \_

\_ \_ \_

\_ \_ \_

\_ \_ \_

\_ Home Phone\_ \_

\_ \_ \_

\_ \_ \_ \_ \_ \_

Name of Employer Work Phone\_ \_ \_ \_

\_ \_ \_

\_ \_ \_ \_

Insurance Company Group Policy#\_

\_ \_ \_

\_ \_ \_

\_ \_ \_

**DO YOU HAVE A SECONDARY DENTAL POLICY? IF YES, PLEASE COMPLETE THE FOLLOWING:**

### Name oflnsured\_ \_ \_

\_ \_ \_

\_ \_ \_

\_ \_ \_

\_ \_ \_

\_ \_ \_ Relationsbip to Patient\_ \_ \_ \_

\_ \_ \_ \_ \_ \_

Address (If different from Patient)\_ \_ \_

\_ \_ \_

\_ \_ \_ \_ \_

\_ \_ \_

\_ \_ \_

\_ \_ \_

\_ \_ \_

\_ \_ \_ \_ \_ \_ \_

Birthdate- - - - - - - - - -

SS#- - - - - - - - - - - -

Home Phone- - - - - - - - - - -

### Name of Employer Work Phone\_ \_ \_ \_

\_ \_ \_

\_ \_ \_ \_

Insurance Company Group Policy#\_ \_ \_ \_

\_ \_ \_

\_ \_ \_

For your convenience, we offer the following methods of payment: Check Cash Visa/Mastercard Discover CareCredit Financing

Payment is expected at the time of service unless prior arrangements have been made.

If the person responsible for this account is different from either the patient or insured party, please notify the receptionist.

**PLEASE TURN OVER AND COMPLETE BACK SIDE OF FORM**

**PATIENT MEDICAL HISTORY (ALL QUESTIONS MUST BE ANSWERED)**

Medical Physician Office Phone Date of Last Exam \_

1. Are you under medical treatment now?\_ \_ \_ \_

\_ \_ \_ \_ \_

9. Are you allergic to any of the following medications?

1. Have you been hospitalized within the last five years? \_

**Please circle or list allergies**

If yes, please explain\_ \_

\_ \_ \_ \_ \_

\_ \_ \_ \_ \_ \_

\_ \_ \_

Local Anesthetics (Novocain, etc.) Penicillin / Amoxicillin

1. Are you currently taking any medication? \_

Ifso, please list all prescriptions and non-prescription medications:

Sulfa Sedatives Iodine Aspirin

Metals (Nickel, Mercury, etc)

1. Have you ever taken Fen-Phen/Redux?\_ \_ \_

\_ \_ \_

\_ \_ \_

Latex

1. Do you use tobacco?\_ \_ \_ \_

\_ \_ \_ \_ \_ \_ \_ \_ \_

\_ \_ \_

Ot her - - - - - - - - - - - - - - - - - - - -

How much?- - - - - - - - - - - - - - - - - - - - -

1. Do you use controlled substances? \_
2. Do you wear contact lenses? \_
3. Do you have or have you ever had any of the following?

**Please circle all that apply**

10. **Women Only:**

Are you pregnant or think you might be pregnant? Yes No Are you nursing? Yes No

Are you taking oral contraceptives? Yes No

## High Blood Pressure Heart Attack Rheumatic Fever Swollen Ankles Fainting/Seizures Asthma

Low Blood Pressure Epilepsy/Convulsions Kidney Disease

Sexually Transmitted Disease

Thyroid Problem Cardiac Pacemaker Heart Murmur Angina

Frequently Tired Anemia Emphysema Cancer Hepatitis/Jaundice

Heart Disease Easily Winded

Hay Fever/Allergies Tuberculosis Radiation Therapy Recent Weight Loss Leukemia

Mitral Valve Prolapse Stomach Troubles/Ulcers

Chest Pains Stroke

Heart Trouble Glaucoma Liver Disease Arthritis Diabetes

Respiratory Problems AIDS or HIV Infection

Joint Replacement/Implant

------------

**PATIENT DENTAL HISTORY**

## Other

### Name of Previous Dentist\_ \_ \_ \_

\_ \_ \_ \_

\_ \_ \_ \_

\_ \_ \_ Date of Last Dental Exam\_ \_

\_ \_ \_

\_ \_ \_ \_ \_

**Please circle any problems you have or have had in the past regarding your oral health:**

Gums bleed while brushing or flossing Biting lips or cheeks frequently

Teeth sensitive to sweet or sour foods Jaw clicking or difficulty chewing Clenching or grinding teeth

Other- - - - - - - - - - - -

Teeth sensitive to hot or cold Lumps or sores in or near mouth Prolonged bleeding after extractions Orthodontic treatment (Braces)

Currently wearing partials or dentures Date of Placement- - - - - - - - -

Difficult extractions in the past Previous jaw, neck or head injuries Pain in any of your teeth

Frequent headaches

Difficulty getting numb with anesthetics