DEAN O. TODD, DDS
PATIENT INFORMATION

Today's Date: _____ Nickname:_____
Patient Name:_____
Mailing Address:_____ M____ F ____ Birthdate:_____
City:_____ SS#_____ Age:_____
State:_____ Zip:_____ Marital Status:_____
Home Phone#:_____ Work Phone #:_____X____
Cell Phone #:_____ Driver's License #:_____
Referred By:_____ Student:_____
If child, parent's name:_____ **E-mail:**_____
Employer:_____ Employer's Address:_____
Occupation:_____ City:_____ State:_____
Spouse's Name:_____ Spouse's SS#:_____
Spouse's Employer:_____ Birthdate:_____
Work #:_____ x_____ Cell:_____ Spouse's D.L. #:_____

PRIMARY INSURANCE:
Company Name:_____
Address:_____
Phone #:_____
Insured's Name:_____
Insured's SS#:_____ DOB:_____
Group #:_____ Relation:_____
Insured's Employer:_____

SECONDARY INSURANCE:
Company Name:_____
Address:_____
Phone #:_____
Insured's Name:_____
Insured's SS#:_____DOB:____
Group #:_____ Relation:_____
Insured's Employer:_____

IN EVENT OF EMERGENCY
Who should we contact?_____
Relation:_____
Home Phone #:_____
Work Phone #:_____
Who is your Medical Doctor?_____
M.D. Phone #: _____

DENTAL HISTORY

How long since your last complete dental cleaning and exam: _____
Were x-rays taken at that time? _____
May we request your previous dental records? _____ If so, please sign release form.
Name of the dentist: _____ Phone #: _____
Address: _____

DENTAL INFORMATION

Reason for today's visit: Exam_____ Emergency _____ Consultation _____
Do you require pre-medication? Yes _____ No _____ Don't know _____
What type of tooth brush bristles do you use? Soft ____ Medium _____ Hard _____
How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

MEDICAL HISTORY

Are you presently under your physician's care? No _____ Yes _____
Are you taking any of the following medications? Nerve pills ____ Pain Killers (including aspirin) _____ Muscle relaxers _____ Stimulants _____ Blood thinners ____ Tranquilizers _____ Insulin _____
Please list all other medication (or provide a written list):
_____
_____
_____
Previous surgeries: _____
Are you or could you be pregnant? Please circle: Yes No

Do you have or had any of the following:

Heart Attack/ Stroke	Y N	Diabetes	Y N
Heart Surgery/ Pacemaker	Y N	Arthritis/ Rheumatism	Y N
Heart Murmur	Y N	Artificial Bones/ Joints	Y N
Rheumatic Fever	Y N	Emphysema	Y N
Sinus Problems	Y N	COPD	Y N
Mitral Valve Prolapse	Y N	Asthma	Y N
Heart Disease	Y N	Alcohol/ Drug Abuse	Y N
Scarlet Fever	Y N	Jaw Problems TMJ	Y N
Tuberculosis (TB)	Y N	Hepatitis A B C	Y N
Cancer	Y N	Anemia	Y N
Chemotherapy	Y N	Allergy to Latex	Y N
HIV+/ AIDS/ ARC	Y N	Seizures/ Epilepsy	Y N
High/ Low Blood Pressure	Y N	Chest Tube	Y N

Are you allergic to any medications? _____ If yes, what _____
Do you use tobacco? No _____ Yes _____

_____ _____
Patient's Signature (Parent signature, if child) **Date**

By signing above, I agree that the above information is correct and accept the financial responsibility for payment of services rendered. I, also, agree to assign benefits of my dental/medical insurance if I have insurance coverage.