MARR & THOMPSON
DENTAL GROUP

Patient Information

Check: ___ Mr. ___ Mrs. ___ Ms. ___ Dr. ___ Rev. ___ Child (under 18) Date _____

Marital Status: ___ Single ___ Married ___ Separated ___ Divorced ___ Widowed Sex: ___ Male ___ Female

Patient's Full Name _____

Soc. Sec. # _____ Birthdate _____

Address _____

City, State, Zip Code _____

Secondary Address for Parents (if different) _____

City, State, Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

E-mail _____

In case of emergency, who should be notified? _____ Phone _____

Personal Physician _____ Phone _____

Person Responsible for Account/Payment (Guarantor) _____

Social Security # _____ Birthdate _____

Address _____

City, State, Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Primary Insurance Information

Policy Holder's Name _____

Relationship to Patient _____

Policy Holder's Date of Birth _____

Policy Holder's SSN# _____

Employer _____

Insurance Company _____

Group Number _____

Member ID# _____

Secondary Insurance Information

Policy Holder's Name _____

Relationship to Patient _____

Policy Holder's Date of Birth _____

Policy Holder's SSN# _____

Employer _____

Insurance Company _____

Group Number _____

Member ID# _____

PLEASE COMPLETE OTHER SIDE

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Patient Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the dental treatment you will receive. Thank you for answering the following questions.

When was your last dental visit? _____

Are you taking any medications, pills or drugs? ❍ Yes ❍ No If yes, please explain: _____

_____

Are you under a physician's care now? ❍ Yes ❍ No If yes, please explain: _____

_____

Are your teeth sensitive to hot, cold or sweets? ❍ Yes ❍ No

Do you clench/grind your teeth or have muscle soreness? ❍ Yes ❍ No

Do you smoke or use tobacco? ❍ Yes ❍ No

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer - Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Have you ever had any serious illness not listed? ❍ Yes ❍ No

COMMENTS: _____

_____

If female, please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature: _____ Date: _____

Patient, Parent or Responsible Party