

**PATIENT INFORMATION**

Mr.  Mrs.  Ms.  Dr. First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Nickname \_\_\_\_\_  
 Sex:  Male  Female Birth Date \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ E-mail \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Tel. (\_\_\_\_) \_\_\_\_\_ Cell. (\_\_\_\_) \_\_\_\_\_ Have you ever been a patient of our practice?  Yes  No  
 Whom may we thank for referring you to our office? \_\_\_\_\_  
 How would you like your appointments confirmed?  Phone call  Email reminder  Text message  
 Driver's Lic.# \_\_\_\_\_ Emergency contact \_\_\_\_\_ Tel. (\_\_\_\_) \_\_\_\_\_  
 Employer \_\_\_\_\_ Bus. Tel. (\_\_\_\_) \_\_\_\_\_

**Who will be responsible for your account?**  Self  Spouse  Father  Mother  Other \_\_\_\_\_

(If self, skip to next section)

Name \_\_\_\_\_ S.S. # \_\_\_\_\_ Birth Date \_\_\_\_\_ Tel. (\_\_\_\_) \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Employer \_\_\_\_\_ Bus. Tel. (\_\_\_\_) \_\_\_\_\_

**Spouse or other guarantor information (if different from above)**

Name \_\_\_\_\_ Relation \_\_\_\_\_ S.S. # \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Tel. (\_\_\_\_) \_\_\_\_\_ Employer \_\_\_\_\_ Bus. Tel. (\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION**

**Student:**  Full Time  Part Time  Not School Name/Address: \_\_\_\_\_  
 Married  Divorced  Separated  Widow  Single \_\_\_\_\_  
**Employed:**  Full Time  Part Time  Retired  Not Do you belong to a PPO or HMO?  Yes  No

**PRIMARY INSURANCE COMPANY**

Insurance Type:  Dental  Medical Employer \_\_\_\_\_ Bus. Tel. (\_\_\_\_) \_\_\_\_\_  
 Plan \_\_\_\_\_ Ins. Co. Name \_\_\_\_\_ Address \_\_\_\_\_  
 Tel. (\_\_\_\_) \_\_\_\_\_ Group # \_\_\_\_\_ Group Name \_\_\_\_\_ Insured Party \_\_\_\_\_  
 Relation \_\_\_\_\_ Sex:  Male  Female Birth Date \_\_\_\_\_ Street \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_ Tel. (\_\_\_\_) \_\_\_\_\_ S.S. # \_\_\_\_\_ I.D. # \_\_\_\_\_

**DENTAL INFORMATION**

Reason for today's visit:  Exam  Consultation  Emergency  
 Are you in pain?  Yes  No If yes, for how long? \_\_\_\_\_  
 Please indicate any of the following problems by checking off the corresponding box:  

<input type="checkbox"/> Discomfort, clicking or popping in jaw	<input type="checkbox"/> Lost / Broken filling(s)	<input type="checkbox"/> Stained teeth	<input type="checkbox"/> Difficulty closing jaw
<input type="checkbox"/> Red, swollen or bleeding gums	<input type="checkbox"/> Teeth grinding /	<input type="checkbox"/> Locking jaw	<input type="checkbox"/> Difficulty opening jaw
<input type="checkbox"/> A removable dental appliance	clenching	<input type="checkbox"/> Bad breath	<input type="checkbox"/> Loose / shifting teeth
<input type="checkbox"/> Blisters / sores in or around the mouth	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Burning tongue /	<input type="checkbox"/> Food caught between
<input type="checkbox"/> Prolonged bleeding from an injury /	<input type="checkbox"/> Broken / chipped tooth	lips	teeth
extraction	<input type="checkbox"/> Gum disease	<input type="checkbox"/> Grind / clench	<input type="checkbox"/> Swelling / lumps in
<input type="checkbox"/> Recent infections or sore throat	<input type="checkbox"/> Toothache	teeth	mouth

My teeth are sensitive to:  Hot  Cold  Sweets  Biting  Other: \_\_\_\_\_  
 Last dental exam \_\_\_\_\_ Last dental x-rays \_\_\_\_\_ Times a day you brush? \_\_\_\_\_  
 Times a week you floss? \_\_\_\_\_ What type of 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 in good health?  Yes  No Are you under the care of a physician?  Yes  No Physician(s) \_\_\_\_\_

Have you had any illness, operation, or been hospitalized in the past five years?  Yes  No Height \_\_\_\_\_ Weight \_\_\_\_\_

**Do you have, or have you had, any of the following diseases, medical conditions or procedures? (Indicate yes or no)**

- | Y                        | N                        | Y                        | N                        | Y  | N                        | Y                        | N                        |
|--------------------------|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic fever          |                          | Asthma                   |                          | Jaundice/Liver disease   |                          | Low blood sugar          |                          |
| Mitral valve prolapse    |                          | Hay fever                |                          | Hepatitis  |                          | Kidney trouble           |                          |
| Heart murmur             |                          | Sinus problems           |                          | HIV/AIDS   |                          | Are you on dialysis      |                          |
| High blood pressure      |                          | Snoring/Sleep apnea      |                          | Infectious mononucleosis   |                          | Arthritis/Joint disease  |                          |
| Low blood pressure       |                          | Respiratory problems     |                          | Gallbladder trouble  |                          | Stomach ulcers           |                          |
| Chest pain / Angina      |                          | Tuberculosis             |                          | Fainting spells  |                          | Contagious diseases      |                          |
| Heart attack(s)          |                          | Emphysema                |                          | Convulsions/Epilepsy   |                          | Delay in healing         |                          |
| Irregular heart beat     |                          | Do you smoke             |                          | Stroke   |                          | Anemia                   |                          |
| Cardiac pacemaker        |                          | Do you chew tobacco      |                          | Thyroid trouble  |                          | Tumor or growth          |                          |
| Heart surgery            |                          | Blood transfusion        |                          | Diabetes   |                          | Radiation                |                          |
| Bronchitis/Chronic cough |                          | Blood disorder           |                          | Type I <input type="checkbox"/> Type II <input type="checkbox"/> |                          | Chemotherapy             |                          |
| Chronic fatigue          |                          | Bruise easily            |                          | Alcohol abuse  |                          | Are you on a diet        |                          |
| Mental health problems   |                          | A history of drug abuse  |                          | STD's  |                          | Contact lenses           |                          |
| Damaged heart valves     |                          | Eye disease/Glaucoma     |                          | Swollen ankles   |                          | Immune system problems   |                          |
| Malignant hyperthermia   |                          | Prolonged bleeding       |                          |  |                          |                          |                          |

## MEDICATION AND ALLERGIES

**Are you now taking: (Indicate yes or no)**

- | Y                              | N                        | Y                        | N                        | Y                        | N                        | Y                        | N                        |
|--------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/>       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nerve pills                    |                          | Pain killers             |                          | Muscle relaxers          |                          | Stimulants               |                          |
| Have you ever taken diet pills |                          | (including aspirin)      |                          | Insulin                  |                          | Antidepressants          |                          |
| Blood thinners                 |                          | Tranquilizers            |                          |                          |                          |                          |                          |
| (Coumadin, Aspirin, Advil)     |                          |                          |                          |                          |                          |                          |                          |

Please list any other medications you are taking (including natural, herbal or homeopathic products):

**Are you allergic to or had a reaction to: (Indicate yes or no)**

- | Y                             | N                        | Y                        | N                        | Y                                     | N                        | Y                        | N                        |
|-------------------------------|--------------------------|--------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin                    |                          | Sulfa drugs              |                          | Local anesthetic (numbing medication) |                          | Sodium pentothal         |                          |
| Valium or other tranquilizers |                          | Aspirin                  |                          | Codeine or other narcotics            |                          | Latex                    |                          |
| Soy                           |                          | Eggs / Yolk              |                          | Sulfites                              |                          | Amoxicillin              |                          |

Please list any other medication or antibiotic you are allergic to:

Please list any allergies other than drug allergies:

**1-4 below for women only: (Women note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional methods of birth control.)**

1) Is there a possibility of pregnancy?  Yes  No

2) Expected delivery date: \_\_\_\_\_

3) Are you nursing?  Yes  No

4) Are you taking birth control pills:  Yes  No

*I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction.*

**Signature of patient: (Parent or Guardian if minor) \_\_\_\_\_ Date: \_\_\_\_\_**

*The signature on file is my authorization for the release of information necessary to process insurance claims on my behalf. I understand that all benefits will be payable directly to me.*

**Signature of patient: (Parent or Guardian if minor) \_\_\_\_\_ Date: \_\_\_\_\_**

*I grant permission for Dr. Burke to take and use clinical photographs for educational and marketing purposes.*

including full face photography  **not** including full face photography

**Signature of patient: (Parent or Guardian if minor) \_\_\_\_\_ Date: \_\_\_\_\_**