Fibonacci Dental Studio

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ABOUT YOU

Name:____ I prefer to be called:______________________ ___Male ___Female
Last First Mi

Birthdate:_____/_____/_____ Age:_____ Social Security #:__________________ __Single __Married __Divorced __Widowed

Home Address:____
Street/PO Box City State Zip

Home Phone #:________________________ Cell Phone #:________________________ Work Phone #:________________________

Email Address:____________________________ Whom may we thank for referring you?____________________________________

Preferred method of contacting you: ___Home phone ___Cell phone ___Text cell phone ___Work phone ___Email

Employer:_____________________________________ Occupation:________________________ How long there?____________

Employer's Address:____
Street/PO Box City State Zip

SPOUSE INFORMATION

Spouse's name:_______________________________________ Birthdate:_____/_____/_____ Social Security #:__________________

Employer:____ Work Phone #:_____________________________

PARENT/GUARDIAN INFORMATION (FOR MINOR PATIENTS)

Name:____________________________ Relation:________ Work Phone #:_______________ Home Phone #:________________

Address:____
Street/PO Box City State Zip

Birthdate:_____/_____/_____ Social Security #:________________________

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name:___________________________ Phone #:__________________ Group #:____________ ID#:______________

Insurance Co. Address:____
Street/PO Box City State Zip

Insured's Name:_____________________ Insured's Social Security #:_____________ Insured's Birthdate____/____/____ Relation:_____

Insured's Employer:________________________ Employer's Address:____
Street/PO Box City State Zip

Secondary Insurance

Insurance Co. Name:___________________________ Phone #:__________________ Group #:____________ ID#:______________

Insurance Co. Address:____
Street/PO Box City State Zip

Insured's Name:_____________________ Insured's Social Security #:_____________ Insured's Birthdate____/____/____ Relation:_____

Insured's Employer:________________________ Employer's Address:____
Street/PO Box City State Zip

DENTAL HISTORY

What brings you in today?____

Previous dentist:______________________ Last visit date:______________________

Question	Y	N	Question	Y	N
Are you currently in any dental pain?	Y	N	Are your teeth sensitive to heat, cold or anything else?	Y	N
Do you have mobility in teeth?	Y	N	Do you floss daily?	Y	N
Do you brush daily?	Y	N	Do your gums ever bleed?	Y	N
Do you still have wisdom teeth?	Y	N	Have you ever had periodontal disease?	Y	N
Do you require antibiotics before dental treatment?	Y	N	Is your mouth dry?	Y	N
Is your home water supply fluoridated?	Y	N	Do you have earaches or neck pains?	Y	N
Do you have clicking, popping or discomfort in jaw?	Y	N	Do you brux or grind your teeth?	Y	N
Do you have sores or ulcers in your mouth?	Y	N	Do you wear dentures or partials?	Y	N

MEDICAL HISTORY

Are you currently under the care of a physician? Y N If yes, please explain:______________________

Physician's Name:____________________ Phone #:______________ Date of last visit:______________

Do you smoke or use tobacco products? Y N **For women**: Are you pregnant? Y N Are you nursing? Y N

DO YOU OR HAVE YOU EXPERIENCED THE FOLLOWING?

Condition	Y	N	Condition	Y	N	Condition	Y	N
Abnormal Bleeding	Y	N	Alcohol Abuse	Y	N	Anemia	Y	N
Arthritis	Y	N	Artificial Bones/Joints	Y	N	Artificial Valves	Y	N
Asthma	Y	N	Auto Immune Disease	Y	N	Blood Transfusion	Y	N
Cancer	Y	N	Chemotherapy	Y	N	Chicken Pox	Y	N
Colitis	Y	N	Congenital Heart Defect	Y	N	Diabetes	Y	N
Difficulty Breathing	Y	N	Drug Abuse	Y	N	Eating Disorder	Y	N
Emphysema	Y	N	Epilepsy	Y	N	Fainting Spells	Y	N
Fever Blisters	Y	N	Gastrointestinal Disease	Y	N	Glaucoma	Y	N
Hay Fever	Y	N	Headaches	Y	N	Heart Attack	Y	N
Heart Murmur	Y	N	Heart Surgery	Y	N	Hemophilia	Y	N
Hepatitis	Y	N	Herpes	Y	N	High Blood Pressure	Y	N
HIV/AIDS	Y	N	Kidney Problems	Y	N	Liver Disease	Y	N
Low Blood Pressure	Y	N	Lupus	Y	N	Mitral Valve Prolapse	Y	N
Pacemaker	Y	N	Persistent Cough	Y	N	Psychiatric Problems	Y	N
Radiation Treatment	Y	N	Rheumatic Fever	Y	N	Scarlet Fever	Y	N
Seizures	Y	N	Shingles	Y	N	Sickle Cell Disease	Y	N
Sinus Problems	Y	N	Steroid Therapy	Y	N	Stroke	Y	N
Swollen Glands in Neck	Y	N	Thyroid Problems	Y	N	Tonsillitis	Y	N
Tuberculosis (TB)	Y	N	Ulcers	Y	N	Venereal Disease	Y	N

Do you have any disease, condition, or problem not listed above that you think I should know about?______________

Please explain:____

List all medications you are taking:____

ALLERGIES

Allergy	Y	N	Allergy	Y	N	Allergy	Y	N	Allergy	Y	N	Allergy	Y	N
Aspirin	Y	N	Penicillin/Antibiotics	Y	N	Barbiturates	Y	N	Narcotics	Y	N	Local Anesthetics	Y	N
Latex	Y	N	Iodine	Y	N	Sulfa Drugs	Y	N	Metals	Y	N			

Other:____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issued prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

______________________________ ______________________

Signature of Patient/Legal Guardian Date