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*Confidential Information - Please complete, sign, date, and return by fax or mail prior to appointment.*

**Adult Patient Information- Age 14 and older**

Name \_\_\_\_\_ Male  Female   
First Middle Last Preferred Name  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Social Security # \_\_\_\_\_ Email \_\_\_\_\_ Name of Spouse \_\_\_\_\_  
Person to contact for emergency \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Name of other family members who are patients in our office \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_

**Responsible Party Information (if different from above)**

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
Employer \_\_\_\_\_ Address \_\_\_\_\_  
Business Phone \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Dental Insurance Information**

**Primary Ins.** Name of Policy Holder \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Social Security # \_\_\_\_\_ NAME OF EMPLOYER \_\_\_\_\_  
Dental Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Insurance ID# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Effective Date \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

**Secondary Ins** Name of Policy Holder \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Social Security # \_\_\_\_\_ NAME OF EMPLOYER \_\_\_\_\_  
Dental Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Insurance ID# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Effective Date \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

*I grant the right to Philip E Strevey, DDS, FAGD to release my information about my dental treatment to third party payors and/or health professionals. I understand that I am financially responsible for all charges whether or not paid by insurance. / authorize the use of this signature on all insurance submissions.*

x \_\_\_\_\_ Date: \_\_\_\_\_  
*Signature of Patient or Responsible Party*

PLEASE SIGN AND COMPLETE ALL 3 PAGES

**ADULT MEDICAL INFORMATION AGE 14 AND OLDER**

Patient Name \_\_\_\_\_

Overall Health:  Excellent  Good  Fair  Poor

Have there been any changes in your general health in the past year?  Yes  No

If yes, what were the changes? \_\_\_\_\_

Date of last complete physical \_\_\_\_\_ Name of Physician \_\_\_\_\_

- Have you ever been diagnosed with Mitral Valve Prolapse?  Yes  No
- Have you ever had an artificial joint or heart valve replacement?  Yes  No
- Have you ever had Rheumatic Fever or Rheumatic Heart Disease?  Yes  No
- Have you ever taken Fen-Phen?  Yes  No Redux?  Yes  No
- Do you smoke?  Yes  No If yes, how much, and for how long? \_\_\_\_\_
- If yes, would you like help quitting?  Yes  No

ARE YOU PREGNANT? YES  NO  Are you taking a birth control pill? YES  NO

ARE YOU OR HAVE YOU EVER TAKEN BISPHTHOSPHONATES FOR OSTEOPOROSIS? YES  NO

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING CONDITIONS? (Please mark boxes that apply)

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Heart Disease or Attack    | <input type="checkbox"/> Hepatitis A or B or C        | <input type="checkbox"/> Multiple Sclerosis           | <input type="checkbox"/> Thyroid Condition     |
| <input type="checkbox"/> Heart Murmur or Pacemaker  | <input type="checkbox"/> HIV + or AIDS                | <input type="checkbox"/> Tumor or Cancer              | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Cold sores of Fever blisters | <input type="checkbox"/> Hives or Skin Rash           | <input type="checkbox"/> Ulcers                |
| <input type="checkbox"/> Kidney Disease             | <input type="checkbox"/> Hay Fever                    | <input type="checkbox"/> Suppressed/Immune Deficiency | <input type="checkbox"/> Nervous Disorder      |
| <input type="checkbox"/> Liver Disease              | <input type="checkbox"/> Headaches                    | <input type="checkbox"/> Epilepsy                     | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Fainting or Dizziness        | <input type="checkbox"/> Persistent Cough             | <input type="checkbox"/> Diabetes              |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Stroke                       | <input type="checkbox"/> Latex Allergy                | <input type="checkbox"/> Glaucoma              |
| <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Hearing Problems             | <input type="checkbox"/> Chronic Pain                 | <input type="checkbox"/> Joint Replacement     |
| <input type="checkbox"/> Gastrointestinal Disorders | <input type="checkbox"/> Blood Disorders              | <input type="checkbox"/> Lung Disease                 |  |

Other conditions not listed ... Please list: \_\_\_\_\_

IF YOU MARKED ANY OF THE ABOVE, PLEASE EXPLAIN:

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

PLEASE LIST ALL PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS YOU ARE TAKING:

- Reason: \_\_\_\_\_
- Reason: \_\_\_\_\_
- Reason: \_\_\_\_\_
- Reason: \_\_\_\_\_
- Reason: \_\_\_\_\_
- Reason: \_\_\_\_\_

PLEASE LIST THE VITAMIN & NUTRITIONAL SUPPLEMENTS YOU ARE TAKING:

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

PLEASE LIST ALL KNOWN ALLERGIES:

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

ADULT DENTAL HISTORY AGE 14 AND OLDER

Patient Name \_\_\_\_\_

Do you have any existing fillings? Yes  No

If yes, are these 'first-time' fillings? Yes  No  If no, have they been filled more than once? Yes  No

Has anyone ever helped you develop a plan to help you keep your teeth for your lifetime? Yes  No

If no, would you like to do this? Yes  No

Have you ever had any negative dental experiences? Yes  No  If yes, please explain. \_\_\_\_\_

Have your parents experienced gum disease?  Yes  No Tooth loss?  Yes  No Explain: \_\_\_\_\_

Do you or have you taken a pre-medication before dental work? Yes  No

If yes, state reason and medication i.e., Joint Replacement, Heart Murmur, Mitral Valve Prolapse, Anxiety \_\_\_\_\_

Do you like the appearance of your teeth? Yes  No  If no, why not: \_\_\_\_\_

Have you ever had braces? Yes  No  If yes, when \_\_\_\_\_ For how long: \_\_\_\_\_ Reason \_\_\_\_\_

What would you change about your mouth, or smile, if you could? \_\_\_\_\_

Do you have a problem with: (please mark all that apply)

- Frequent headaches  Jaw pain  Ringing in your ears  Jaw joint 'noises'
 Dry mouth  Bleeding gums  Wisdom teeth  Clenching or Grinding your teeth

Have you ever worn a mouth 'night guard' or 'splint'? Yes  No  If yes, when? \_\_\_\_\_

Reason \_\_\_\_\_

Do you currently have any pain or sensitivity? Yes  No  If yes, please describe \_\_\_\_\_

Date of your last dental visit: \_\_\_\_\_ Reason \_\_\_\_\_

May we obtain your former dental history and X-Rays? Yes  No

Name of Previous Dentist: \_\_\_\_\_ Location: \_\_\_\_\_

Why did you leave your last dentist? \_\_\_\_\_

Is there any other information that we need to know or that you would like to share with us regarding your needs and our care for you? \_\_\_\_\_

What is the reason for your visit? \_\_\_\_\_

What are your 'oral health' goals? \_\_\_\_\_

I verify that all personal, medical, and dental information is correct,

SIGNATURE

Date: \_\_\_\_\_

(If under 18 years of age, Signature of Parent or Guardian Required)