11924 W. Forest Hill Blvd #10B, Wellington, FL 33414
Tel: 561-721-2688 Fax: 561-721-2680

PERSONAL, MEDICAL & DENTAL HISTORY

Welcome! We are pleased to welcome you to our office. Please fill out this form as completely as you can. The following information is essential for our staff to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to safely and efficiently protect your dental needs. If you have any questions, we would be glad to help you. We look forward to working with you in maintaining good dental health.

PATIENT INFORMATION

LAST NAME_____FIRST NAME_____MIDDLE INITIAL_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____WORK PHONE_____**CELL PHONE**_____

SS #_____DOB_____EMAIL ADDRESS_____

DRIVER'S LICENSE #_____PREFERRED NAME_____

SEX ☐ M ☐ F MARRIED DIVORCED WIDOWED SINGLE SEPARATED MINOR PARTNER

EMPLOYER_____EMPLOYER ADDRESS_____

SPOUSE or PARENT'S NAME_____EMPLOYER_____WORK #_____

WHOM MAY WE THANK FOR REFERRING YOU_____PHONE #_____

PERSON TO CONTACT IN CASE OF EMERGENCY_____ PHONE #_____

WHEN DO YOU PREFER TO HAVE YOUR APPOINTMENTS? (PLEASE CIRCLE) MORNING AFTERNOON EVENING SATURDAY

RESPONSIBLE PARTY

Name of Person Responsible for This Account_____Relation to Patient_____

Address_____Home Phone_____

Employer_____Birthdate_____

Driver's License #_____SS #_____Currently a patient in our office? Y N

Work Phone_____Cell Phone_____Email _____

INSURANCE INFORMATION

Name of Insured_____Relation to Patient_____

DOB_____SS#_____Employer_____

Employer Address_____

Insurance Company_____Group #_____ID#_____

PLEASE INFORM OUR OFFICE IF YOU HAVE ADDITIONAL DENTAL INSURANCE COVERAGE

MEDICAL HISTORY

Physician's name_____Phone #_____Date of Last Visit_____

Are you currently under the care of a **physician**_____For What?_____

Medications you are currently taking_____

List drug/medicine allergies_____

Have you ever had any serious illnesses or operations? Y N If yes, describe_____

Have you ever had a blood transfusion? Y N If yes, give dates_____

Any allergy to: Aspirin Codeine Dental Anesthetics Penicillin Latex Sulfa Iodine Other_____

(Women) Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N Hormone meds? Y N

Check (✓) if you have or have had problems with any of the following:

☐ Anemia	☐ Congenital Heart lesions	☐ Hepititis	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cortisone Treatments	☐ Hernia Repair	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough, Persistent	☐ High Blood Pressure	☐ Skin Rash
☐ Artificial Joints, Pins, etc.	☐ Cough up Blood	☐ HIV/AIDS	☐ Stroke
☐ Asthma	☐ Diabetes	☐ Jaw Pain	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Epilepsy	☐ Kidney Disease	☐ Thyroid Problems
☐ Bleeding Abnormally	☐ Fainting	☐ Liver Disease	☐ Tobacco Habit
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tuberculosis
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Ulcer
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Venereal Disease
☐ Circulatory Problems	☐ Hemophilia	☐ Rheumatic fever	

DENTAL HISTORY

Reason for today's vist_____Date of last dental care_____

Former Dentist_____Date of last dental X-rays_____

Address_____Phone #_____

Check (√) if you have or have had problems with any of the following:

☐ Abscess in mouth ☐ Any food traps ☐ Bad breath ☐ Bad tastes ☐ Bite nails/objects ☐ Bleeding gums

☐ Blisters—lip mouth ☐ Chew on one side ☐ Chew tobacco ☐ Clenching teeth ☐ Difficulty chewing ☐ Cold sores

☐ Chew on one side ☐ Pain around ears ☐ Dry mouth ☐ Gag easily ☐ Infection in gums ☐ Missing teeth

☐ Pain in jaw joint ☐ Loose teeth ☐ Sensitive gums ☐ Sensitive to: Hot Cold Sweets Sour

What is your Main Concern about your teeth?_____

Do you have any special concerns regarding your visit? Fear Time Money Tension Other_____

Describe any previous problems you may have had with past dental treatment_____

_____

I give Noble Dental consent to use local anesthetic as needed or to use nitrous oxide per my request. I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. If there is any changes in my medical status, I will inform Noble Dental. Since at each visit a treatment plan will be presented and the work to be done is explained to me before treatment is begun, I give Noble Dental my consent to perform any needed dental treatment. I authorize my insurance company to pay to Noble Dental all insurance benefits otherwise payable to me for services rendered and to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. **I understand that I am fully financially responsible for ALL charges whether covered or not covered or denied by my insurance company.**

SIGNATURE_____PRINT_____DATE_____