3180 N. Butler Ave. Bldg. 200
Farmington, NM 87401

# WELCOME TO OUR OFFICE!

## Patient Information

Patient's Name:_______________________________________________ Birthdate:______________________

Name you like to be called:_____________________ Hm. Phone:_______________ Cell:_________________

Address:________________________________________ City:______________ State:_______ Zip:________

Social Security #:____________________________ Do you play a musical instrument? ☐Yes ☐No

If patient is a minor, give parent or guardian's name(s):_____________________________________________________

Patients Email Address:________________________ Responsible Party's email address:_______________________

Who may we thank for referring you to our office?_______________________________________________

Number of Siblings:_____ Names and ages of siblings:_______________________________________________

Have we treated any other family members? ☐ No ☐ Yes; Who:__________________________________________

School:__________________Grade:________________ Favorite thing(s) to do:_________________________

## RESPONSIBLE PARTY

Name: ____________________________________________________ Marital Status:___________________

Address:________________________________________ City:______________ State:_______ Zip:________

Mailing Address *(if different)*:____________________________ City:______________ State:_______ Zip:________

How long at this address?_________Social Security #: _____________________ Birthdate:__________________

Previous Address:________________________________ City:______________ State:_______ Zip:________

Relationship to Patient: ____________Home/Cell#: __________________ Work #: _______________________

Employer: ___________________________ Occupation:______________ No. of years employed: ___________

Spouses Name: ________________________________________ Relationship to Pt:_____________________

Spouses Employer:___________________________ Occupation:______________ No. of years Employed:______

Spouses Social Security #:_______________________________________ Spouses Birthdate:________________

## INSURANCE INFORMATION

Insured Name: _______________________ Insured's SS#:__________________ Insured's Birthdate: ________

Insurance Co:___________________________________________________________________________

Insurance Co. Address:______________________________________________ Group #:________________

Phone:________________________ Insured's Employer:___________________________________________

Do you have dual coverage? ☐Yes ☐No If yes:__________________________________________________

Insured's Name: ______________________ Insured's SS#:__________________ Insured's Birthdate: ________

Insurance Co. ___________________________________________________________________________

Insurance Co. Address:______________________________________________ Group #:________________

Phone:________________________ Insured's Employer:___________________________________________

**OVER**

**Patients Full Name:**_______________________________________________ **Date:**___________________________

## MEDICAL/DENTAL HISTORY

Physician's Name:___________________________________________________________ Phone: ____________________

Dentists Name: _____________________________________________________________ Phone: ____________________

☐Yes ☐No Are you currently under any medical treatment?_______________________________________________________

☐Yes ☐No Do you have pain, clicking, and/or popping noises in the jaw?_________________________________________

☐Yes ☐No Are you aware of either clenching or grinding of teeth?______________________________________________

☐Yes ☐No Do you have frequent headaches? How often?_______________________________________________________

☐Yes ☐No Do you have ear problems? (Aches, ringing, dizziness, fullness)______________________________________

☐Yes ☐No Do you have difficulty breathing through the nose?___________________________________________________

☐Yes ☐No Do you have habits such as nail biting, finger or thumb sucking, lip or cheek biting?__________________________

☐Yes ☐No Do you have speech problems, or are you in speech therapy?_________________________________________

☐Yes ☐No Have you had your tonsils and/or adenoids removed?____________________________________________________

☐Yes ☐No Has there been any history of: ☐ Diabetes ☐ Osteoporosis ☐ Joint swelling ☐ Asthma or sinus trouble

☐ Aids or HIV ☐ Kidney problems ☐ Liver Condition ☐ Epilepsy ☐ Seizures ☐ Neurological problems

☐ Rheumatic fever ☐ Thyroid or Endocrine ☐ Cancer or cancer treatment ☐ Tumor ☐ Anemia ☐ TB

☐ Rheumatoid or Arthritic conditions ☐ Other major illnesses?__________________________________________

☐Yes ☐No Do you bleed easily?______________________________________________________________________

☐Yes ☐No Is there a tendency to faint or become dizzy?______________________________________________________

☐Yes ☐No Do you have a heart condition? ☐Yes ☐No Do you pre-medicate? ☐Yes ☐No Cardiologist:__________________

☐Yes ☐No Are you currently or have you ever taken oral or intravenous bisphosphonates?

☐Yes ☐No Do you have sleep apnea?__________________________________________________________________

☐Yes ☐No Do you smoke or chew tobacco?_____________________________________________________________

☐Yes ☐No Do you currently have or ever had a substance abuse problem?

☐Yes ☐No Have there been any injuries to the teeth?__________________________________________________________

☐Yes ☐No Have you had any permanent teeth extracted?________________________________________________________

**☐Yes ☐No Do you have an allergy or reaction to any of the following:**

**☐ Metals (jewelry, clothing snaps) ☐ Latex (gloves, balloons) ☐Vinyl ☐ Acrylic**

**☐Other Substance:**_____________________________________________________

**☐Yes ☐No Do you have allergies to any drugs or medication? (Ibuprofen, Sulfa, Penicillin, Novocain, etc.)**

**Please list:**______________________________________________________________

**☐Yes ☐No Are you currently taking any medication? List:**_____________________________________________________

**<u>WOMEN ONLY:</u>**

**☐Yes ☐No Are you pregnant or do you anticipate becoming pregnant?**

**I have read and understand the above questions. I will not hold Dr. Graff or any member of his staff responsible for any errors or omissions that I have made in completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.**

**Signed:** _______________________________________________________ **Date Signed:**___________________________________

**(Patient or parent/responsible party)**

**Signed:** _______________________________________________________ **Date Signed:**___________________________________

**(Dental Staff Member)**