MARINER DENTAL

About You:

Name:_____ I prefer to be called _____ □ Male □ Female
Home Address:_____ City_____ State_____ Zip_____
Home # _____ Cell # _____ Work # _____ Ext. _____
Birthdate:__/__/__ Age:_____ SS #:_____ Driver's License _____
□ Single □ Married □ Widowed □ Separated
Student: □ No □ Yes □ Full Time □ Part Time Where:_____
Employer: _____ Employer's Address: _____
How long employed? _____ Occupation_____
Whom may we thank for referring you? _____
Previous Dentist:_____ Last visit date: _____
Person responsible for account:_____
Home #_____ Work #_____
Billing Address _____ City _____ State _____ Zip _____
Relationship to patient _____ SS#_____ Driver's License _____
Employer:_____ Employer's Address: _____

Spouse's Information

Spouse's Name:_____ Employer:_____
Work #_____ Ext:_____ SS #_____

Primary Dental Insurance

Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co. Phone #_____ Group # (Plan, Local or Policy #) _____
Subscriber's Name:_____ Subscriber's Birthdate: ___/___/___ SS#_____
Subscriber's Employer:_____

Secondary Dental Insurance

Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co. Phone #_____ Group # (Plan, Local or Policy #) _____
Subscriber's Name:_____ Subscriber's Birthdate: ___/___/___ SS#_____
Subscriber's Employer:_____

Medical History

Do you have a personal physician? □ No □ Yes
Physician's Name: _____ Phone #_____ Date of last visit ___/___/___

In the event of an emergency, is there someone who lives near you that we should contact?
Name:_____ Relationship:_____
Work #_____ Ext:_____ Home #_____
Your current physical health is: □ Good □ Fair □ Poor
Are you currently under the care of a physician: □ No □ Yes
If Yes, please explain:_____
Are you taking any prescription / over the counter drugs? □ No □Yes
Please list:_____
Are you taking birth control pills? □ No □ Yes Are you pregnant? □ No □ Yes If yes, week # _____
Are you nursing? □ No □ Yes
Do you smoke? □ No □ Yes How much? _____ Do you use chew tobacco? □ No □ Yes
Have you ever taken bisphosphonates? □ No □ Yes
Have you ever had any of the following diseases or medical problems?

Y N Heat Attack / Stoke	Y N Diabetes	Y N Cancer/chemotherapy	Y N Tuberculosis
Y N Heart Murmur	Y N Drug/Alcohol Abuse	Y N Rheumatic Fever	Y N Venereal Disease
Y N HIV/AIDS	Y N Hemophilia	Y N Heart Surgery	Y N Pacemaker
Y N Bleeding Problems	Y N Ulcers/Colitis	Y N Mitral Valve Prolapse	Y N Heart Defects
Y N Kidney Problems	Y N Radiation Treatment	Y N Artificial Valves	Y N Asthma
Y N Sinus Problems	Y N Arthritis	Y N Blood Pressure	Y N Difficulty Breathing
Y N Fever Blisters	Y N Hospitalization	Y N Headaches	Y N Hepatitis
Y N Psychiatric Problems	Y N Emphysema	Y N Blood Thinner	Y N Daily Aspirin
Y N Osteoporosis	Y N Epilepsy	Y N Seizures	Y N Glaucoma

Have you ever had a sleep study? □ No □ Yes
Have you ever been diagnosed with sleep apnea? □ No □ Yes If yes, how many nights do you wear you CPAP?
_____
Please list any serious medical conditions that you ever had: _____
_____
Are you allergic to any of the following drugs?

Y N Penicillin	Y N Tetracycline	Y N Latex	Y N Erythromycin	
Y N Aspirin	Y N Dental Anesthetics	Y N Codeine	Y N Sulfa	Y N Other Allergies

Please list any other drugs that you are allergic to: _____

Dental History

Are you currently in pain? □ No □ Yes If yes, please explain _____
Have you ever had a serious, difficult problem associated with any previous dental work? □ No □ Yes
If yes, please explain _____
Do you now or have you ever experienced pain/discomfort in your jaw joint? □ No □ Yes

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform with my informed consent, any necessary dental services I may need during diagnosis and treatment.

Signature _____ Date _____