IRWIN DENTAL CENTER

Print Form Submit Form

Confidential Responsible Party Information

Responsible Party Name _____ (Last / First / Middle) Marital Status _____

Residence _____ (Street / City / State / Zip)

Mailing Address _____ (Street / City / State / Zip)

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____ (Street / City / State / Zip) How long _____

Cell Phone _____ E-mail _____ Preferred Method of Contact ☐ Text ☐ Call ☐ Email

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name (If Applicable) _____ (Last / First / Middle)

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____ Cell Phone _____

Confidential Patient Information If Other Than Responsible Party

Patient's Name _____ (Last / First / Middle)

Address _____ (Street / City / State / Zip)

Home Phone _____ Cell Phone _____ E-mail _____

Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Insurance Information

Policy Holder's Name _____ DOB _____ Insurance ID # _____

Policy Holder's Address _____ (Street / City / State / Zip)

Policy Holder's Employer _____

Insurance Company _____ Group No. _____ Group Name _____

Insurance Co. Address _____ Insurance Co. Phone _____

Do you have dual coverage? ☐ No ☐ yes If yes, complete Insurance Information below

Policy Holder's Name _____ DOB _____ Insurance ID # _____

Policy Holder's Address _____ (Street / City / State / Zip)

Policy Holder's Employer _____

Insurance Company _____ Group No. _____ Group Name _____

Insurance Co. Address _____ Insurance Co. Phone _____

Emergency Information

Name of nearest relative not living with you _____ Relationship _____

Complete Address _____ Phone _____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

X _____ _____

PATIENT, PARENT OR GUARDIAN DATE

UPDATES

(DATE & INITIAL) _____

(DATE & INITIAL) _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY PRESCRIPTION, NON-PRESCRIPTION OR ILLICIT DRUGS?	☐	☐

IF YES, WHAT ARE YOU TAKING? _____

_____

_____

4. DO YOU TAKE OR HAVE YOU EVER TAKEN ANY OF THE FOLLOWING DRUGS?

FOSAMAX ☐ ACTONEL ☐ BONIVA ☐

ZOMETA ☐ AREDIA ☐ HOW LONG? _____

	YES	NO
5. DO YOU USE TOBACCO?	☐	☐

6. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	LOCAL ANESTHETICS (EG. NOVOCAINE)	☐	☐	BARBITURATES	☐	☐	ASPIRIN
☐	☐	PENICILLIN OR OTHER ANTIBIOTICS	☐	☐	SEDATIVES	☐	☐	OTHER _____
☐	☐	SULFA DRUGS	☐	☐	IODINE			_____

7. WOMEN ONLY:

	YES	NO
A) ARE YOU PREGNANT OR THINK YOU MAY BECOME PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS / HIV Positive	☐	☐	Congenital Heart Disorder	☐	☐	Hemophilia	☐	☐	Psychiatric Care	☐	☐
Alzheimer's Disease	☐	☐	Cortisone Medicine	☐	☐	Hepatitis A	☐	☐	Radiation Treatments	☐	☐
Anaphylaxis	☐	☐	Diabetes	☐	☐	Hepatitis B or C	☐	☐	Renal Dialysis	☐	☐
Anemia	☐	☐	Drug Addiction	☐	☐	Herpes	☐	☐	Rheumatic Fever	☐	☐
Angina / Chest Pain	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Scarlet Fever	☐	☐
Arthritis / Gout	☐	☐	Epilepsy or Seizures	☐	☐	Hives or Rash	☐	☐	Shingles	☐	☐
Artificial Heart Valve	☐	☐	Excessive Bleeding	☐	☐	Hypoglycemia	☐	☐	Sinus Trouble	☐	☐
Artificial joint	☐	☐	Fainting Spells / Dizziness	☐	☐	Kidney Problems	☐	☐	Stomach / Intestinal Disease	☐	☐
Asthma	☐	☐	Frequent Cough	☐	☐	Leukemia	☐	☐	Stroke	☐	☐
Blood Disease	☐	☐	Frequent Diarrhea	☐	☐	Liver Disease	☐	☐	Swelling of Limbs	☐	☐
Blood Transfusion	☐	☐	Frequent Headaches	☐	☐	Low Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Breathing Problem	☐	☐	Glaucoma	☐	☐	Lung Disease	☐	☐	Tonsillitis	☐	☐
Bruise Easily	☐	☐	Heart Attack / Failure	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis	☐	☐
Cancer	☐	☐	Heart Murmur	☐	☐	MRSA	☐	☐	Tumors or Growths	☐	☐
Chemotherapy	☐	☐	Heart Pace Maker	☐	☐	Pain in Jaw Joints	☐	☐	Ulcers	☐	☐
Cold Sores / Fever Blisters	☐	☐	Heart Trouble / Disease	☐	☐	Parathyroid Disease	☐	☐			

Have you ever had any serious illness not listed above? ☐ YES ☐ NO If yes, please explain: _____

COMMENTS: _____

PATIENT DENTAL HISTORY

PREVIOUS DENTIST _____

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS / FOODS?	☐	☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS / FOODS?	☐	☐
4. DO YOU FEEL ANY PAIN TO ANY OF YOUR TEETH?	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐	☐
7. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
A) CLICKING?	☐	☐
B) PAIN (JOINT, EAR, SIDE FACE)?	☐	☐
C) DIFFICULTY IN OPENING OR CLOSING?	☐	☐
D) DIFFICULTY IN CHEWING?	☐	☐
8. DO YOU HAVE FREQUENT HEADACHES?	☐	☐

	YES	NO
9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
12. HAVE YOU EVER HAD ANY ORTHODONTIC WORK?	☐	☐
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
14. HAVE YOU EVER HAD INSTRUCTION ON THE CARE OF YOUR GUMS?	☐	☐
15. DO YOU HAVE A DRY MOUTH AS A RESULT OF MEDICATIONS?	☐	☐

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(DATE & INITIAL) _____

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