Clifton Family Dentistry
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310 Terrace Avenue, Suite 102
Cincinnati, Ohio 45220
513-221-1550

PATIENT INFORMATION:

NAME_____ SEX: M/F DATE OF BIRTH_____
SOCIAL SECURITY#_____ Phone_____
ADDRESS_____ APT #_____
CITY_____ STATE_____ZIP CODE_____
Mobile phone_____ Home phone_____ preferred phone line (circle one) W M H phone

Work phone_____ Employer_____ Occupation_____
Years employed _____ Are you a student? **Y/ N** If yes, what school? _____
Marital status_____ Spouse's Name _____
Emergency Contact_____ Relationship to Patient_____
Emergency Contact Phone_____

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

Who is responsible for this account? _____

I understand that I am responsible for all fees regardless of insurance coverage.

Signature of patient/parent_____

DENTAL INSURANCE INFORMATION:

Subscriber's name_____ Date of birth_____ Sex: M F
Address_____ Phone_____
Social Security number_____ Employer_____ Phone_____
Insurance company_____ Insurance company phone#_____
Group #_____ID#_____
Patient's relationship to subscriber: Self____ Spouse____ Dependent____

Are you covered by more than one dental insurance plan? Y N *If yes, complete the following:*

Subscriber's name_____ Date of birth_____ Sex: M F
Address_____ Phone_____
Social Security number_____ Employer_____ Phone_____
Insurance company_____ Insurance company phone#_____
Group #_____ID#_____
Patient's relationship to subscriber: Self____ Spouse____ Dependent____

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Reason for today's visit _____
When was your last cleaning? _____ X-Rays? _____
What was your last dental visit, if not a cleaning? _____
How many times a week do you floss? _____ How many times a day do you brush?_____
Previously, how long were your dental cleaning appointments? **30 mins. 45 mins. 60 mins.**
Have you ever been told you have gum disease? **Y / N**
If yes, did you receive treatment for your gum disease? **Y/ N** Dates of treatment_____
Describe treatment:_____
Are you nervous about having dental treatment? **Y/ N** If yes, explain: _____
_____
How do you feel about the appearance of your teeth? _____
If you could change anything, what would you change about your smile? _____
_____
Do you have any of the following problems?

Tooth Sensitivity	Clenching	Swollen Gums
Headaches	Grinding	Bad Breath
Sleep Apnea	Bleeding Gums	Jaw Joint Issues/Pain

Have you been treated by a Doctor, or been hospitalized in the past 2 years? **Y /N** If yes, explain: _____
_____
Have you ever been treated for bleeding or a tumor? **Y /N** Explain:_____
_____
Please list any medications *(prescription, herbals, over the counter, Birth Control, vitamins, etc.)* you are **currently taking** or **have taken** in the past year: _____
_____
_____
Are you on a special diet? **Y/N** If yes, explain_____
Do you have to sleep with more than 1 pillow, or sitting up? **Y/N** Why? _____
Do you smoke? **Y/N** How much? _____ How long? _____ Have you quit? When? _____
WOMEN: Are you pregnant? **Y/N** If yes, what is your due date? _____
Please list any ALLERGIES (medications, latex, jewelry etc.)_____
Do you have Mitral valve prolapse, heart valve replacements, or artificial joints? Y N
Have you ever or are you now taking any **Bisphosphonates or** other medicines for osteoporosis? **Y N**

Please circle any of the following medical/dental conditions that may apply:

AIDS/HIV+	Diabetes	Hepatitis A, B, C	
Alzheimer's Disease	Drug Addiction	Herpes	Rheumatism
Anemia	Easily Winded	High Blood Pressure	Scarlet Fever
Angina	Emphysema	Hives or Rashes	Shingles
Arthritis/Gout	Epilepsy/Seizures	Hypoglycemia	Sickle Cell Disease
Artificial Heart Valve	Excessive Bleeding	Irregular Heartbeat	Sinus Trouble
Artificial Joint	Excessive Thirst	Kidney Stones	Spina Bifida
Asthma	Fainting/Dizziness	Leukemia	Stomach/Intestinal Disease
Blood Disease	Frequent Cough	Liver Disease	Stroke
Blood Transfusion	Frequent Diarrhea	Low Blood Pressure	Swelling of Limbs
Breathing Problems	Frequent Headaches	Lung Disease	Thyroid Disease
Bruising Easily	Glaucoma	Mitral Valve Prolapse	Tonsillitis
Cancer	Hay Fever	Parathyroid Disease	Tuberculosis
Chemotherapy	Heart Attack/Failure	Psychiatric Care	Tumors/Growths
Chest Pains	Heart Murmur	Radiation Treatment	Ulcers
Cold Sores/Fever Blisters	Heart Pace Maker/Defibrillator	Recent Weight Loss	Yellow Jaundice
Congenital Heart Disorder	Heart Trouble/Disease	Renal Dialysis	
Cortisone Medicine	Hemophilia	Rheumatic Fever	

Any condition not listed above: _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health or medications, I will inform the Dentist at my next appointment without fail.

Patient/Parent signature _____ Date_____