Patient Information (Confidential)

Name_____ Date_____
First Middle Last

Address_____ City_____State_____Zip_____
Cell #_____ Soc. security #_____Birth date_____Home phone_____
Email_____

Check Appropriate Box ☐ Minor ☐ Single ☐Married ☐Divorced ☐Widowed ☐Separated

If college student, F.T./P.T., name of school_____ City_____State_____
Patient's or parent's employer_____ Work phone_____
Business address _____ City_____State_____Zip_____
Spouse or parent's name _____Employer_____Work phone_____
Whom may we thank for referring you _____
Person to contact in case of an emergency _____ Phone_____

Responsible Party

Name of person responsible for this account _____ Relationship to patient_____
Address_____Home Phone_____
Driver's license #_____Birth date_____Soc. security #_____
Employer_____ Work phone_____
Is this person currently a patient in our office ☐ Yes ☐ No

Insurance Information

Name of insured _____ Relationship to patient_____
Birth date_____ Soc. security #_____Date employed_____
Name of employer_____ Union or local #_____Work phone_____
Employer address _____ City_____State_____Zip_____
Insurance co._____ Tel. #_____Grp. #_____Policy/I.D. #_____
Ins. co. address_____ City_____State_____Zip_____
How much is your deductible _____ How much have you used_____Max annual benefit_____

Do you have any additional insurance ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Relationship to patient_____
Birth date_____ Soc. security #_____Date employed_____
Name of employer_____ Union or local #_____Work phone_____
Employer address _____ City_____State_____Zip_____
Insurance co._____ Tel. #_____Grp. #_____Policy/I.D. #_____
Ins. co. address_____ City_____State_____Zip_____
How much is your deductible _____ How much have you used_____Max annual benefit_____

X_____ _____

Signature of patient or parent if minor **Patient number**

Patient Medical History

Patient's Name _____ **Date of Birth**_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	YES	NO
1. Are you in good health _____	☐	☐
2. Have there been any changes in your general health within the past year _____	☐	☐
3. Date of your last physical exam _____		
4. Physician's name _____		
Address _____		
Phone no. _____		
5. Are you now under the care of a physician _____	☐	☐
6. Have you ever been hospitalized for any surgical operation or serious illness _____	☐	☐
Please explain _____		
7. Are you taking any medicine(s), including non-prescription medicine? _____	☐	☐
If yes, what medicine(s) are you taking _____		
_____		
8. Have you had any abnormal bleeding _____	☐	☐
9. Do you bruise easily _____	☐	☐
10. Have you ever required a blood transfusion _____	☐	☐
11. Have you had a recent weight loss _____	☐	☐
12. Have you ever taken Fen-Phen or Redux _____	☐	☐
13. Do you use tobacco _____	☐	☐
14. Do you or have you used controlled substances _____	☐	☐
15. Are you wearing contact lenses _____	☐	☐
16. Do you have any disease, condition, or problem not listed above that you think I should know about ___	☐	☐
Women only:		
Are you pregnant or think you may be pregnant _____	☐	☐
Are you nursing _____	☐	☐
Are you taking birth control pills _____	☐	☐

	YES	NO
Are you allergic to or have you had reactions to:		
Local anesthetics like novocaine _____	☐	☐
Penicillin or other antibiotics _____	☐	☐
Sulfa drugs _____	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐
Aspirin _____	☐	☐
Iodine _____	☐	☐
Any metals (e.g., nickel, mercury, etc.) _____	☐	☐
Latex/rubber _____	☐	☐
Other (please list) _____		
Do you have, or have you ever had, any of the following:		
Rheumatic heart disease or rheumatic fever _____	☐	☐
Scarlet fever _____	☐	☐
Heart defect or heart murmur _____	☐	☐
Heart trouble, heart attack, or angina _____	☐	☐
Chest pain _____	☐	☐
Shortness of breath _____	☐	☐
Pacemaker _____	☐	☐
Heart surgery _____	☐	☐
High/low blood pressure _____	☐	☐
Congenital heart problem _____	☐	☐
Swelling of feet, ankles, hands _____	☐	☐
Hepatitis, jaundice, or liver disease _____	☐	☐
Stroke _____	☐	☐
Sinus trouble _____	☐	☐
Lung or breathing problems _____	☐	☐
Asthma or hay fever _____	☐	☐
Hives or skin rash _____	☐	☐
Fainting or dizzy spells _____	☐	☐
Diabetes _____	☐	☐
AIDS or HIV infection _____	☐	☐
Thyroid problem _____	☐	☐
Allergies _____	☐	☐
Arthritis or rheumatism _____	☐	☐
Joint replacement or implant _____	☐	☐
Stomach ulcer _____	☐	☐
Kidney trouble _____	☐	☐
Tuberculosis _____	☐	☐
Persistent cough _____	☐	☐
Cough that produces blood _____	☐	☐
Chemotherapy (cancer, leukemia) _____	☐	☐
Sexually transmitted disease _____	☐	☐
Epilepsy or seizures _____	☐	☐
Anemia _____	☐	☐
Glaucoma _____	☐	☐
Nervousness _____	☐	☐
Tonsillitis _____	☐	☐
Tumors _____	☐	☐
Mental health care _____	☐	☐
Back problems _____	☐	☐
Chemical dependency _____	☐	☐
Mitral valve prolapse _____	☐	☐
Cortisone treatment _____	☐	☐
Cold sores/fever blisters _____	☐	☐
Hypoglycemia _____	☐	☐
Eating disorders _____	☐	☐

Patient Dental History

Patient's Name _____ **Date of Birth**_____

Reason for this visit_____

When was your last dental visit_____What was done then_____

How often did you visit the dentist before then _____

Previous dentist (name and location) _____

Have you had a complete series of dental exams (x-rays) taken? When and where _____

How often do you brush your teeth_____ How often do you floss your teeth_____

Is your drinking water fluoridated _____

	YES	NO
Do your gums bleed while brushing or flossing_____	☐	☐
Are your teeth sensitive to hot or cold liquids/foods _____	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods_____	☐	☐
Do you feel pain to any of your teeth _____	☐	☐
Do you have any sores or lumps in or near your mouth ____	☐	☐
Have you had any head, neck, or jaw injuries_____	☐	☐
Have you ever experienced any of the following problems in your jaw?		
Clicking _____	☐	☐
Pain (joint, ear, side of face) _____	☐	☐
Difficulty in opening or closing_____	☐	☐
Difficulty in chewing_____	☐	☐
Do you have frequent headaches _____	☐	☐
Do you clench or grind your teeth _____	☐	☐
Do you bite your lips or cheeks frequently _____	☐	☐

	YES	NO
Have you noticed any loosening of your teeth _____	☐	☐
Does food tend to become caught between your teeth_____	☐	☐
Have you ever had periodontal treatment (gums)_____	☐	☐
Ever worn a bite plate or other appliance _____	☐	☐
Have you ever had any difficult extractions in the past_____	☐	☐
Have you ever had any prolonged bleeding following extractions _____	☐	☐
Do you wear dentures or partials _____	☐	☐
If yes, date of placement _____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums_____	☐	☐
Have you had ortho/braces in the past _____	☐	☐
Would you be interested in teeth whitening_____	☐	☐
Have you had an unfavorable dental experience _____	☐	☐

If you could change <u>anything</u> about your smile, what would you change? _____

_____

_____

Appointments: A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. Once an appointment is made, please remember this time has been reserved for you.

Authorization and Release

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 providing incorrect information can be dangerous to my health. I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____Date_____

Signature of patient or parent if minor

Doctor's Comments_____

_____

_____**Signature**_____**Date**_____

_____**Patient Number**