PATIENT INFORMATION

COMPLETION OF THIS FORM IN ITS ENTIRETY IS REQUIRED AT THE TIME OF VISIT/TREATMENT

Name _____ Social Security # _____

Date of Birth _____ Age_____

Home Address _____ City _____ State _____ Zip _____

Home Phone_____ Work Phone_____ Cell Phone_____

Employer _____ Occupation_____

Spouse/Parent Name _____ Social Security #_____

Spouse/Parent Employer _____

Relative to contact other than spouse/parent_____Phone_____

Who may we thank for referring you to this office? _____

How do you intend to pay? Cash_____ Check_____ Credit Card_____ Insurance_____ Medicaid_____

DENTAL INSURANCE INFORMATION

Name of Insurance Company _____ Phone _____

Address _____City _____ State _____ Zip _____

Group # _____

Name of Insured (Employee) _____ Date of Birth_____

ID# _____ Employer _____

If someone other than the patient is responsible for payment, please complete the following:

Name of responsible party _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Home Phone_____ Work Phone_____ Social Security #_____

PLEASE SIGN AND RETURN TO THE RECEPTIONIST

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent appointments, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits.

Patient/Parent Signature_____ Date_____

PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient Name _____ Date of Birth_____ Age _____

Name of your physician _____ Date of last visit to physician _

Name of your previous dentist_____ Date of last visit to dentist_____

MEDICAL HEALTH HISTORY

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE CHECK ANY THAT APPLY.

Heart Problems_____ ❑
- Chest pain _____ ❑
- Shortness of breath _____ ❑
- Blood pressure problem _____ ❑
- Heart murmur _____ ❑
- Heart valve problem _____ ❑
- Taking heart medication _____ ❑
- Rheumatic fever _____ ❑
- Pacemaker _____ ❑
- Artificial heart valve _____ ❑

Blood Problems _____ ❑
- Easy bruising_____ ❑
- Frequent nose bleeds _____ ❑
- Abnormal Bleeding _____ ❑
- Blood disease (anemia)_____ ❑

Allergy Problems _____ ❑
- Hay fever _____ ❑
- Sinus problems_____ ❑
- Skin rashes _____ ❑
- Taking allergy medication _____ ❑
- Asthma_____ ❑

Intestinal Problems _____ ❑
- Ulcers_____ ❑
- Weight gain or loss _____ ❑
- Special diet _____ ❑
- Constipation_____ ❑

Bone or Joint Problems_____ ❑
- Arthritis_____ ❑
- Back or neck pain _____ ❑
- Joint replacement (e.g., total hip) _____ ❑

Fainting Spells, Seizures, or Epilepsy _____ ❑

Diabetes_____ ❑
- Urinate more than 6 times a day _____ ❑
- Thirsty or mouth is dry much of the time_____ ❑
- Family history of diabetes_____ ❑

Tuberculosis or other respiratory disease _____ ❑

Cancer/Tumor_____ ❑

Do you drink? _____ ❑
- If so, how much? _____ ❑

Do you smoke? _____ ❑
- If so, how much? _____ ❑

Hepatitis, Jaundice, or Liver Trouble _____ ❑

Herpes _____ ❑

HIV-Positive/AIDS _____ ❑

Glaucoma _____ ❑

Do you wear contact lenses?_____ ❑

Are you allergic or have you reacted adversely to any of the following?

- **Local anesthetics ("Novocaine")** _____ ❑
- **Penicillin or other antibiotics** _____ ❑
- **Sulfa drugs**_____ ❑
- **Barbiturates, sedatives, or sleeping pills**_____ ❑
- **Aspirin** _____ ❑
- **Codeine**_____ ❑
- **Other** _____

During the past 12 months have you taken any of the following?

- **Antibiotics or sulfa drugs** _____ ❑
- **Anticoagulants (e.g., Coumadin)** _____ ❑
- **High blood pressure medicine** _____ ❑
- **Tranquilizers** _____ ❑
- **Insulin, Orinase, or similar drug** _____ ❑
- **Aspirin** _____ ❑
- **Digitalis or drugs for heart trouble** _____ ❑
- **Nitroglycerin** _____ ❑
- **Cortisone (steroids)** _____ ❑
- **Bisphosphonate** _____ ❑
- **Other** _____

Women

Are you taking contraceptives or other hormones? ___ ❑
Are you pregnant? _____ ❑
- **If so, expected delivery date:** _____

Have any of your babies weighed more than nine pounds? _____ ❑
Have you reached menopause? _____ ❑
- **If so, do you have any symptoms?** _____ ❑

DENTAL HEALTH HISTORY

PLEASE MARK ANY OF THE QUESTIONS THAT YOU WOULD ANSWER "YES":

Are you apprehensive about dental treatment? _____ ❑
Have you had problems with previous dental treatment? _____ ❑
Do you gag easily? _____ ❑
Do you wear dentures? _____ ❑
Does food catch between your teeth? _____ ❑
Do you have difficulty in chewing your food? _____ ❑
Do you chew on only one side of your mouth? _____ ❑
Do you avoid brushing any part of your mouth because of pain? _____ ❑
Do your gums bleed easily? _____ ❑
Do your gums bleed when you floss? _____ ❑
Do your gums feel swollen or tender? _____ ❑
Have you ever noticed slow healing sores in or about your mouth? _____ ❑
Are your teeth sensitive? _____ ❑

Do you feel twinges of pain when your teeth come in contact with:

Hot foods or liquids? _____ ❑
Cold foods or liquids? _____ ❑
Sours? _____ ❑
Sweets? _____ ❑

Do you take fluoride supplements? _____ ❑
Are you dissatisfied with the appearance of your teeth? _____ ❑
Do you prefer to save your teeth? _____ ❑
Do you want complete dental care? _____ ❑
How often do you brush? _____ How often do you floss? _____
Does your jaw make noise so that it bothers you or others? _____ ❑
Do you clench or grind your jaws frequently? _____ ❑
Do your jaws ever feel tired? _____ ❑
Does your jaw get stuck so that you can't open freely? _____ ❑
Does it hurt when you chew or open wide to take a bite? _____ ❑
Do you have earaches or pain in the front of the ears? _____ ❑
Do you have any jaw symptoms or headaches upon awaking in the morning? _____ ❑
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities? _____ ❑
Do you find jaw pain or discomfort extremely frustrating or depressing? _____ ❑
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)? ❑
Do you have a temporomandibular disorder (TMD, TMJ)? _____ ❑
Do you have pain in the face, cheeks, jaw, joints, throat, or temples? _____ ❑
Are you unable to open your mouth as far as you want? _____ ❑
Are you aware of an uncomfortable bite? _____ ❑
Have you had a blow to the jaw (trauma)? _____ ❑
Are you a habitual gum-chewer or pipe smoker? _____ ❑
Do you have any disease, condition or problem not listed that you feel we should know about? _____ ❑

If so, please describe: _____

_____

_____

Patient Signature _____ Date _____

Submit

(or print document to bring with you on your office visit)