

PATIENT INFORMATION FORM

Name: _____ Nickname: _____

Address: _____
Street City / State Zip Code

Employer _____ Occupation _____

Home Ph.# _____ Work Ph.# _____ Fax.# _____

Cell Ph.# _____ Pager # _____

SS# _____ Birthdate _____ Drivers Lic: _____

Spouse's Name _____ Employed by: _____

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

PERSON RESPONSIBLE FOR PAYMENT

Name _____ Relationship to patient _____

Address: _____
Street City / State Zip Code

Employer _____ Occupation _____

Home Ph.# _____ Work Ph.# _____ Fax.# _____

SS# _____ Birthdate _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company _____ Group # _____

Insured's Name _____ SS# _____ DOB _____

DENTAL HISTORY

Do you have a dental complaint at this time? _____

What was the date of your last dental treatment? _____

How often did you see your dentist? _____

Have you ever had an unpleasant dental experience? _____

Who was your last dentist and where? _____

Do you grind or clench your teeth? Yes No

Do you have pain in your jaw joint? Yes No

Do you have sore or sensitive teeth? Yes No

Do your gums bleed? Yes No

Do you get cold or canker sores? Yes No

Do you have an unpleasant taste in your mouth? Yes No

Do you have frequent headaches? Yes No

Do you have ear aches? Yes No

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do you have any: Loose____ Cracked____ Broken teeth____? Check all that apply

Have you had periodontal treatment? _____

Have you ever worn braces? _____ When? _____ Dr's name: _____

Do you have any missing teeth? _____ Have they been replaced? _____

If so how? Fixed bridge____ Removable partial____ Denture____ Implant____

How do you feel about the appearance of your smile? _____

Would you be interested in whiter teeth? _____ , or cosmetic dentistry to improve your smile? _____

Name of spouse or parents _____

Work place of spouse _____ phone number _____

Whom should we contact in case of an emergency? _____

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

MEDICAL HISTORY

PATIENT NAME _____

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 be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No N/A _____

Have you ever been hospitalized or had a major operation? Yes No N/A _____

Have you ever had a serious head or neck injury? Yes No N/A _____

Are you taking any medications, pills, or drugs? Yes No N/A _____

Do you take, or have you taken, Phen-Fen or Redux ? Yes No N/A Do you use tobacco? Yes No N/A

Are you on a special diet? Yes No N/A Do you use controlled substances? Yes No N/A

Women: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptive?

Are you allergic to any of the following?

Aspirin Penicillin Codine Acrylic Metal Latex Local Anesthetics Other _____

Do you have, or have you had, any of the following?

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No N/A _____

Comments: _____

*Condition may require medication N/A - Not answered by patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN

DATE