

# PATIENT INFORMATION

Welcome to our office. The information provided on this form is important to your dental health. If there have been any changes in your health, please inform us. If you have questions, please don't hesitate to ask. All information is confidential.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 SSN: \_\_\_\_\_ Email: \_\_\_\_\_ Referred to us by: \_\_\_\_\_  
 Are any of your family members patients of this practice? Y N Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Emerg. contact name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

<b>Primary Dental Insurance</b> (Leave blank if none) Insurance Company: _____ Policy #: _____ Group #: _____ Subscriber's Name: _____ DOB: _____ SSN: _____	<b>Billing Information</b> (if responsible party is other than patient) Billing Name: _____ Billing Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ SS #: _____
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## DENTAL HEALTH HISTORY

Name of previous dentist: \_\_\_\_\_ Last visit: \_\_\_\_\_ Last x-rays: \_\_\_\_\_

What is the reason for this appointment? \_\_\_\_\_

**Are any of your teeth sensitive to:**

Hot or Cold? ..... Y N  
 Sweets? ..... Y N  
 Biting or pressure? ..... Y N  
 Have you ever noticed any unpleasant tastes or odors? ..... Y N  
 Do you frequently get cold sores, blisters or any mouth sores? ..... Y N

**Do you:**

Clench or grind your teeth while awake or asleep? ..... Y N  
 Have tired jaws, especially early in the morning? ..... Y N  
 Bite your lips or cheeks regularly? ..... Y N  
 Hold objects with your teeth? (pencils, pins, nails, etc.) ..... Y N  
 Breath mainly through your mouth? ..... Y N  
 Snore? ..... Y N

**Do your gums bleed or hurt?** ..... Y N  
 Have your parents had gum disease or tooth loss? ..... Y N  
 Have you noticed any loose teeth or bite changes? ..... Y N  
 Does food tend to become caught between your teeth? Y N

**Have you ever had:**

Orthodontic treatment? ..... Y N  
 Oral surgery? ..... Y N  
 Periodontal Treatment? ..... Y N  
 Gum Surgery? ..... Y N  
 If so, when? \_\_\_\_\_  
 By whom? \_\_\_\_\_  
 A bridge? If so, when? ..... Y N  
 A serious injury to the mouth or head? ..... Y N  
 If so, please describe: \_\_\_\_\_

**Have you ever experienced:**

Clicking or popping of the jaw? ..... Y N  
 Pain in your face or near your ears? ..... Y N  
 Difficulty opening or closing the mouth? ..... Y N  
 Frequent headaches, neck aches, or shoulder aches? ..... Y N

**Are you dissatisfied with the appearance of your teeth?** Y N  
 Are your teeth discolored? ..... Y N  
 Are your teeth crooked? ..... Y N

If there anything else about dental treatment that you would like us to know, please describe. \_\_\_\_\_

**Notes:** \_\_\_\_\_

**CONSENT:**

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) \_\_\_\_\_  
 I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine due and payable at the time services are rendered unless other arrangements have been made. An 18% yearly finance fee (1.5% monthly) will be charged to all accounts with balance due for over 30 days after insurance payment.
4. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_

Parent or Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## MEDICAL HEALTH HISTORY

Name of your medical doctor(s): \_\_\_\_\_ Phone number: \_\_\_\_\_

Condition being treated: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Please list any medications you are taking (please include *any* natural remedies, supplements, and non-prescription drugs): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list any past surgeries, hospitalizations or serious illnesses (please note any complications): \_\_\_\_\_  
 \_\_\_\_\_

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

Heart Problems .....	Y	N	Thyroid problems .....	Y	N
Chest pain/angina .....	Y	N	Persistent or bloody cough .....	Y	N
Shortness of breath .....	Y	N	Adrenal/pituitary problems.....	Y	N
Blood pressure abnormality (circle: high or low) ...	Y	N	Frequent infections/difficulty healing .....	Y	N
Heart murmur .....	Y	N	Cancer/Tumor/Other growths.....	Y	N
Heart valve defect (ex. mitral valve prolapse) .....	Y	N	Surgical removal?.....	Y	N
Artificial heart valve .....	Y	N	Chemotherapy or Radiation?.....	Y	N
Heart attack .....	Y	N	<b>Antibiotic Premedications required</b> .....	Y	N
Rheumatic fever .....	Y	N	<b>Allergic/Adverse reaction to:</b>		
Pacemaker .....	Y	N	Local anesthetics ("Novocaine").....	Y	N
Bypass surgery.....	Y	N	Penicillin or other antibiotics .....	Y	N
Swollen ankles .....	Y	N	Sulfa drugs .....	Y	N
Stroke .....	Y	N	Aspirin, Acetaminophen, or Ibuprofen .....	Y	N
Any bleeding disorders.....	Y	N	Codeine, Demerol, or other narcotics .....	Y	N
Easy bruising/nosebleeds.....	Y	N	Reaction to metals .....	Y	N
Abnormal or prolonged bleeding .....	Y	N	Latex or rubber.....	Y	N
Blood disease (anemia/hemophilia) .....	Y	N	Other _____		
Blood transfusion .....	Y	N	Diabetes .....	Y	N
Sickle cell trait/anemia .....	Y	N	Urinate more than 6 times a day .....	Y	N
Lung/Breathing Problems .....	Y	N	Thirsty or mouth is dry much of the time .....	Y	N
Hay fever/Sinus problems.....	Y	N	Family history of diabetes.....	Y	N
Tuberculosis.....	Y	N	Do you drink alcohol? .....	Y	N
Emphysema/Bronchitis .....	Y	N	If so, how much _____		
Skin rashes .....	Y	N	Do you smoke or use chewing tobacco?.....	Y	N
Asthma .....	Y	N	If so, how much _____		
Intestinal Problems .....	Y	N	Hepatitis, jaundice, or liver trouble .....	Y	N
Ulcers .....	Y	N	If hepatitis, indicate type: A B C		
Weight gain or loss (significant).....	Y	N	Herpes or other STD .....	Y	N
Special diet .....	Y	N	HIV-positive/AIDS .....	Y	N
Constipation/Diarrhea .....	Y	N	Glaucoma .....	Y	N
Kidney or bladder problems .....	Y	N	Psychological/Mental disorder .....	Y	N
Bone, Joint, or Muscular Problems .....	Y	N	Swollen glands or fever .....	Y	N
Arthritis .....	Y	N	History of alcohol or drug addiction .....	Y	N
Back or neck pain .....	Y	N	Anorexia or bulimia .....	Y	N
Joint replacement (ex. hip, pins, or implants) .....	Y	N	Have you taken any steroids in the past 6 months? .....	Y	N
Dizziness, fainting spells, seizures, epilepsy or other neurological disorder.....	Y	N	Women:	Y	N
Frequent or severe headaches .....	Y	N	Are you pregnant? .....	Y	N
			Are you nursing? .....	Y	N

Do you have any current health conditions not listed above, please describe:

**Patient/Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Doctor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Doctor Notes:** \_\_\_\_\_  
 \_\_\_\_\_