

PATIENT INFORMATION

CONFIDENTIAL

(PLEASE PRINT)

DATE _____

NAME _____ BIRTHDATE _____

FIRST MI LAST

HOME PHONE # _____ CELL PHONE # _____ WORK PHONE # _____

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

E-MAIL _____ SOCIAL SECURITY # _____

CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

IF PATIENT IS A FULL TIME STUDENT, NAME OF SCHOOL / COLLEGE _____

CITY _____ STATE/PROV. _____ ZIP/P.C. _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY (IF NOT PATIENT)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ FINANCIAL INSTITUTION _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____

GROUP # _____ MEMBER ID # _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____

GROUP # _____ MEMBER ID # _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

<p>1. ARE YOU UNDER MEDICAL TREATMENT NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____</p> <p>4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. DO YOU USE TOBACCO? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>7. ARE YOU WEARING CONTACT LENSES? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">YES NO</td> <td style="width: 33%;">YES NO</td> <td style="width: 33%;">YES NO</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> LOCAL ANESTHETICS (E.G. NOVOCAINE)</td> <td><input type="checkbox"/> <input type="checkbox"/> BARBITURATES</td> <td><input type="checkbox"/> <input type="checkbox"/> ASPIRIN</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> PENICILLIN OR OTHER ANTIBIOTICS</td> <td><input type="checkbox"/> <input type="checkbox"/> SEDATIVES</td> <td><input type="checkbox"/> <input type="checkbox"/> LATEX/RUBBER</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> SULFA DRUGS</td> <td><input type="checkbox"/> <input type="checkbox"/> IODINE</td> <td><input type="checkbox"/> <input type="checkbox"/> OTHER</td> </tr> <tr> <td></td> <td></td> <td style="text-align: center;">YES NO</td> </tr> </table> <p>9. DO YOU HAVE DRY MOUTH BECAUSE OF MEDICATIONS OR ANY OTHER REASONS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>10. WOMEN ONLY:</p> <p>A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>B) ARE YOU NURSING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>C) ARE YOU TAKING BIRTH CONTROL PILLS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	YES NO	YES NO	YES NO	<input type="checkbox"/> <input type="checkbox"/> LOCAL ANESTHETICS (E.G. NOVOCAINE)	<input type="checkbox"/> <input type="checkbox"/> BARBITURATES	<input type="checkbox"/> <input type="checkbox"/> ASPIRIN	<input type="checkbox"/> <input type="checkbox"/> PENICILLIN OR OTHER ANTIBIOTICS	<input type="checkbox"/> <input type="checkbox"/> SEDATIVES	<input type="checkbox"/> <input type="checkbox"/> LATEX/RUBBER	<input type="checkbox"/> <input type="checkbox"/> SULFA DRUGS	<input type="checkbox"/> <input type="checkbox"/> IODINE	<input type="checkbox"/> <input type="checkbox"/> OTHER			YES NO	
YES NO	YES NO	YES NO															
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		YES NO															

11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES NO	YES NO	YES NO
<input type="checkbox"/> <input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> <input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> <input type="checkbox"/> CHEST PAINS
<input type="checkbox"/> <input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> <input type="checkbox"/> CARDIAC PACEMAKER	<input type="checkbox"/> <input type="checkbox"/> EASILY WINDED
<input type="checkbox"/> <input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> <input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> <input type="checkbox"/> STROKE
<input type="checkbox"/> <input type="checkbox"/> SWOLLEN ANKLES	<input type="checkbox"/> <input type="checkbox"/> ANGINA	<input type="checkbox"/> <input type="checkbox"/> HAY FEVER / ALLERGIES
<input type="checkbox"/> <input type="checkbox"/> FAINTING / SEIZURES	<input type="checkbox"/> <input type="checkbox"/> FREQUENTLY TIRED	<input type="checkbox"/> <input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> <input type="checkbox"/> ASTHMA	<input type="checkbox"/> <input type="checkbox"/> ANEMIA	<input type="checkbox"/> <input type="checkbox"/> RADIATION THERAPY
<input type="checkbox"/> <input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> <input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> <input type="checkbox"/> GLAUCOMA
<input type="checkbox"/> <input type="checkbox"/> EPILEPSY / CONVULSIONS	<input type="checkbox"/> <input type="checkbox"/> CANCER	<input type="checkbox"/> <input type="checkbox"/> RECENT WEIGHT LOSS
<input type="checkbox"/> <input type="checkbox"/> LEUKEMIA	<input type="checkbox"/> <input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> <input type="checkbox"/> LIVER DISEASE
<input type="checkbox"/> <input type="checkbox"/> DIABETES	<input type="checkbox"/> <input type="checkbox"/> JOINT REPLACEMENT OR IMPLANT	<input type="checkbox"/> <input type="checkbox"/> HEART TROUBLE
<input type="checkbox"/> <input type="checkbox"/> KIDNEY DISEASES	<input type="checkbox"/> <input type="checkbox"/> HEPATITIS / JAUNDICE	<input type="checkbox"/> <input type="checkbox"/> RESPIRATORY PROBLEMS
<input type="checkbox"/> <input type="checkbox"/> AIDS OR HIV INFECTION	<input type="checkbox"/> <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE	<input type="checkbox"/> <input type="checkbox"/> OTHER _____
<input type="checkbox"/> <input type="checkbox"/> THYROID PROBLEM	<input type="checkbox"/> <input type="checkbox"/> STOMACH TROUBLES / ULCERS	

PATIENT DENTAL HISTORY

	YES	NO		YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	<input type="checkbox"/>	<input type="checkbox"/>	8. DO YOU HAVE FREQUENT HEADACHES?	<input type="checkbox"/>	<input type="checkbox"/>
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	<input type="checkbox"/>	<input type="checkbox"/>	9. DO YOU CLENCH OR GRIND YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	<input type="checkbox"/>	<input type="checkbox"/>	10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	<input type="checkbox"/>	<input type="checkbox"/>
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>	11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	<input type="checkbox"/>	<input type="checkbox"/>
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	<input type="checkbox"/>	<input type="checkbox"/>	12. HAVE YOU HAD ANY ORTHODONTIC WORK?	<input type="checkbox"/>	<input type="checkbox"/>
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	<input type="checkbox"/>	<input type="checkbox"/>	13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	<input type="checkbox"/>	<input type="checkbox"/>
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?			14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>
A) CLICKING?	<input type="checkbox"/>	<input type="checkbox"/>	15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	<input type="checkbox"/>	<input type="checkbox"/>
B) PAIN (JOINT, EAR, SIDE OF FACE)?	<input type="checkbox"/>	<input type="checkbox"/>			
C) DIFFICULTY IN OPENING OR CLOSING?	<input type="checkbox"/>	<input type="checkbox"/>			
D) DIFFICULTY IN CHEWING?	<input type="checkbox"/>	<input type="checkbox"/>			

HOW LONG SINCE YOUR LAST DENTAL EXAM X-RAYS WERE TAKEN? _____

HAVE YOU EVER HAD A DEEP CLEANING OR PERIODONTAL TREATMENT? _____ WHEN? _____

I HAVE REVIEWED THE ATTACHED MEDICAL HISTORY. MY (OR THE PATIENTS) HEALTH AND MEDICATIONS HAVE CHANGED AS FOLLOWS (IF NO CHANGE, WRITE "NO CHANGE").

SIGNATURE

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.

X

PATIENT, PARENT OR GUARDIAN

DATE