

PATIENT INFORMATION AND HEALTH HISTORY

DATE: _____

PATIENT NAME: _____
SINGLE MARRIED LONG TERM PARTNER DIVORCED SEPERATED WIDOWED

DATE OF BIRTH: _____ SS#: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

EMPLOYER: _____ BUSINESS PHONE: _____

PERSON RESPONSIBLE FOR ACCOUNT: _____

REFERRED BY: _____

DENTAL INSURANCE

PRIMARY

SECONDARY

INSURANCE CO: _____

GROUP #: _____

EMPLOYER: _____

INSURED:

LAST NAME: _____

FIRST NAME: _____

SS# OR ID #: _____

DATE OF BIRTH: _____

RELATIONSHIP: _____

AUTHORIZATION

I authorize my insurance company to pay to the dentist group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date: _____

OVER →

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING-INDICATE WITH (✓)

- | | | |
|--|---|--|
| <input type="checkbox"/> ALLERGY TO DRUGS _____
<input type="checkbox"/> ALLERGY TO LATEX
<input type="checkbox"/> ALLERGY TO ANESTHETICS
<input type="checkbox"/> ANEMIA
<input type="checkbox"/> ARTHRITIS
<input type="checkbox"/> ARTIFICIAL JOINTS (HIP/KNEE REPLACEMENT)
<input type="checkbox"/> ASPRIN REGIMEN
<input type="checkbox"/> ASTHMA
<input type="checkbox"/> CANCER/MALIGNANCIES
<input type="checkbox"/> CHRONIC FATIGUE
<input type="checkbox"/> COUMADIN THERAPY
<input type="checkbox"/> DIABETES
<input type="checkbox"/> EPILEPSY | <input type="checkbox"/> EXCESSIVE BLEEDING
<input type="checkbox"/> EYE DISORDERS/GLAUCOMA
<input type="checkbox"/> FAINTING
<input type="checkbox"/> HAY FEVER/ALLERGIES
<input type="checkbox"/> HEAD INJURIES
<input type="checkbox"/> HEART AILMENTS/DISEASE
<input type="checkbox"/> HEART MURMUR
<input type="checkbox"/> HIGH BLOOD PRESSURE
<input type="checkbox"/> IMMUNE SYSTEM DISORDER (AIDS, HIV)
<input type="checkbox"/> KIDNEY DISEASE
<input type="checkbox"/> LIVER DISEASE/HEPATITIS
<input type="checkbox"/> LUPUS
<input type="checkbox"/> MITRAL VALVE PROLAPSE (MVP) | <input type="checkbox"/> NEUROLOGICAL PROBLEMS
<input type="checkbox"/> PACEMAKER
<input type="checkbox"/> PREGNANCY WHAT MONTH _____
<input type="checkbox"/> PHYCHIATRIC/EMOTIONAL PROBLEMS
<input type="checkbox"/> RADIATION TREATMENT
<input type="checkbox"/> RHEUMATIC FEVER
<input type="checkbox"/> RESPIRATORY PROBLEMS
<input type="checkbox"/> SINUS PROBLEMS
<input type="checkbox"/> STOMACH PROBLEMS
<input type="checkbox"/> STROKE
<input type="checkbox"/> THYROID
<input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> ULCERS/COLITIS
<input type="checkbox"/> VENERAL DISEASE |
|--|---|--|

DO YOU PRE-MEDICATE WITH ANTIBOTICS PRIOR TO DENTAL TREATMENT? YES OR NO IF SO, WITH WHAT? _____

DESCRIBE ANY CURRENT MEDICAL TREATMENT _____

WHAT MEDICATIONS ARE YOUR TAKING? _____

DENTAL HISTORY

CHIEF ORAL COMPLAINT _____

DATE OF LAST DENTAL EXAM _____

ANY PREVIOUS MAJOR DENTAL TREATMENT YES NO

WHEN: _____

HAVE YOU HAD OR DO YOU USE ANY OF THE FOLLOWING INDICATE WITH (✓)

- | | | |
|--|---|--|
| <input type="checkbox"/> TEETH SENSITIVITY TO COLD, HEAT, SWEETS, PRESSURE
<input type="checkbox"/> BLEEDING GUMS HOW LONG? _____
<input type="checkbox"/> FOOD IMPACTION
<input type="checkbox"/> CLENCHING OR GRINDING
<input type="checkbox"/> BURNING OF TONGUE
<input type="checkbox"/> SWELLING OR LUMPS IN MOUTH
<input type="checkbox"/> PAIN AROUND EAR
<input type="checkbox"/> UNUSUAL SOUNDS IN EAR WHILE EATING
<input type="checkbox"/> BAD BREATH | <input type="checkbox"/> PERIODONTAL TREATMENT
<input type="checkbox"/> ORTHODONTIC TREATMENT
<input type="checkbox"/> MOUTH BREATHING
<input type="checkbox"/> ORAL HABITS, FINGERNAIL/CHEEK BITING
<input type="checkbox"/> CIGARETTE, PIPE OR CIGAR SMOKING
<input type="checkbox"/> TEXTURE OF TOOTHBRUSH _____
<input type="checkbox"/> FREQUENCY OF BRUSHING _____
<input type="checkbox"/> DENTAL FLOSS | <input type="checkbox"/> INTER DENTAL STIMULATORS
<input type="checkbox"/> WATER JET DEVICE
<input type="checkbox"/> DISCLOSING TABLETS OR SOLUTION
<input type="checkbox"/> FLUORIDE SUPPLEMENTS
<input type="checkbox"/> UNPLEASANT TASTE
<input type="checkbox"/> UNFAVORABLE DENTAL EXPERIENCE
<input type="checkbox"/> COMPLICATIONS FROM EXTRACTIONS
<input type="checkbox"/> ALCOHOL |
|--|---|--|

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8		
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17		
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8		

APPOINTMENTS