

PATIENT INFORMATION AND HEALTH HISTORY

DATE _____

PATIENT'S NAME _____ DATE OF BIRTH _____
SINGLE MARRIED LONG TERM PARTNER DIVORCED SEPARATED WIDOWED

PATIENT'S ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____ CELL PHONE _____

EMPLOYED BY _____ PATIENT'S SS# _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ REFERRED BY _____

PRIMARY DENTAL INSURANCE

Last Name _____ First Name _____ Middle Initial _____

Relation to Patient _____ Birthdate _____ Insured SS# _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Group # _____

SECONDARY DENTAL INSURANCE

Is patient covered by additional insurance Yes No Insured's SS# _____

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed By _____ Business Phone (____) _____

Insurance Company _____

Group# _____

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 changes whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

OVER →

DENTAL HISTORY

CHIEF ORAL COMPLAINT _____

DATE OF LAST DENTAL EXAM. _____ ANY PREVIOUS MAJOR DENTAL TREATMENT, YES NO WHEN _____

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Teeth sensitive to cold, heat, sweets or pressure | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Cigarettes, pipe or cigar smoking |
| <input type="checkbox"/> Bleeding gums. How long _____ | <input type="checkbox"/> Unpleasant taste | <input type="checkbox"/> Texture of toothbrush _____ |
| <input type="checkbox"/> Food impaction | <input type="checkbox"/> Unfavorable dental experience | <input type="checkbox"/> Frequency of brushing _____ |
| <input type="checkbox"/> Clenching or grinding | <input type="checkbox"/> Complications from extractions | <input type="checkbox"/> Dental Floss |
| <input type="checkbox"/> Burning of tongue | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Inter dental stimulators |
| <input type="checkbox"/> Swelling or lumps in mouth | <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Water jet device |
| <input type="checkbox"/> Frequent blisters on lips or mouth | <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Disclosing tablets or solution |
| <input type="checkbox"/> Pain around ear | <input type="checkbox"/> Oral habits, i.e., fingernail biting | <input type="checkbox"/> Fluoride supplements |
| <input type="checkbox"/> Unusual sounds in ear while eating | cheek biting, etc. | <input type="checkbox"/> Alcohol |

MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM. _____ AGE _____

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergies to drugs _____ | <input type="checkbox"/> Asthma | <input type="checkbox"/> Immune System Disorders (AIDS, HIV, ARC) |
| <input type="checkbox"/> Allergies to anesthetics | <input type="checkbox"/> Hay fever or allergies in general | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Any heart ailments _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Eye disorders |
| <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Latex sensitivity | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Radiation treatments | <input type="checkbox"/> Liver problems or hepatitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Excessive bleeding from cut or extraction | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Ulcer or colitis |
| <input type="checkbox"/> Anemia or blood problems | <input type="checkbox"/> Psychiatric care/emotional problems | <input type="checkbox"/> Pregnancy If so, what month _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Other _____ |

Do you pre-medicate prior to dental treatment? Yes / no. If so with what? _____

Do you take Aspirin daily? Yes / no

Describe any current medical treatment including drugs taken, even though not listed above. _____

APPOINTMENTS

NAME _____ DATE _____ AGE _____

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