

PATIENT INFORMATION

**PAUL M. BANKS, DDS
ANDREW L. HOWARD, DMD**

Name: _____
Preferred Name: _____
Today's Date: _____



Address:	Home Phone Number:
	Mobile Phone Number:
	Email Address:
Date of Birth:	Work Phone Number:
Sex: M F	Social Security Number:
Marital Status: S M W D Minor	Driver's License #:
Employer:	Occupation:
Whom may we thank for referring you to our office?	
Dental Insurance Information	
Insured's Name:	Insurance Company:
Insured's Date of Birth:	Insurance Group #:
Insured's Employer:	Insurance ID:

NAME: _____

Medical Information

Name of Physician:	Physician Phone Number:
Have you been under a physician's care in the last two years?	Date of last physical exam?
If yes, for what reason?	
Do you require premedication for your dental visit?	

HEALTH HISTORY

Have you ever had an allergic or adverse reaction to:

<input type="checkbox"/> Aspirin, ibuprofen, acetaminophen	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Erythromycin
<input type="checkbox"/> Novacaine	<input type="checkbox"/> Fluoride	<input type="checkbox"/> Sulphas	<input type="checkbox"/> Local Anesthesia
<input type="checkbox"/> Metals (nickel, gold, silver)	<input type="checkbox"/> Valium	<input type="checkbox"/> Latex	<input type="checkbox"/> Other
<input type="checkbox"/> Tetracycline			

Please list all medications, supplements, and/or vitamins you are currently taking:

Medication/Dosage	Purpose

Are you taking or have you taken a bisphosphonate (ex. Zometa, Aredia, Fosamax, Boniva)?

Are you taking blood thinners or daily aspirin?

MEDICAL HISTORY

Do you have or have you ever had?	Y	N		Y	N
Hospitalization for illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems or cardiac stent within the last six months?	<input type="checkbox"/>	<input type="checkbox"/>	Head or neck injuries?	<input type="checkbox"/>	<input type="checkbox"/>
History of infective endocarditis?	<input type="checkbox"/>	<input type="checkbox"/>	Seizures?	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve, repaired heart defect?	<input type="checkbox"/>	<input type="checkbox"/>	ADD or ADHD?	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker or implantable defibrillator?	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disease?	<input type="checkbox"/>	<input type="checkbox"/>
Artificial prosthesis (heart valve or joints)	<input type="checkbox"/>	<input type="checkbox"/>	Cold sores?	<input type="checkbox"/>	<input type="checkbox"/>
High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Lumps or swelling in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
A stroke?	<input type="checkbox"/>	<input type="checkbox"/>	Hives, rash?	<input type="checkbox"/>	<input type="checkbox"/>
Anemia or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever or seasonal allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged or excessive bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease?	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema or sarcoidosis?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis? (Type _____)	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or abnormal growth?	<input type="checkbox"/>	<input type="checkbox"/>
Snoring or sleep apnea?	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy or Radiation therapy?	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>	Emotional problems?	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease?	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice?	<input type="checkbox"/>	<input type="checkbox"/>	Antidepressant medication?	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid, parathyroid disease?	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol or drug dependency?	<input type="checkbox"/>	<input type="checkbox"/>
Hormone deficiency?	<input type="checkbox"/>	<input type="checkbox"/>	Aware of any change in your general health?	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol or taking statin medication?	<input type="checkbox"/>	<input type="checkbox"/>	Taking dietary supplements?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes? (Type 1 or 2)? (circle one)	<input type="checkbox"/>	<input type="checkbox"/>	Subject to frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Stomach or duodenal ulcer?	<input type="checkbox"/>	<input type="checkbox"/>	MALE: prostate disorders?	<input type="checkbox"/>	<input type="checkbox"/>
Digestive disorder (ie. GERD)?	<input type="checkbox"/>	<input type="checkbox"/>	FEMALE: pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis/ostopenia?	<input type="checkbox"/>	<input type="checkbox"/>	FEMALE: taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>			
ARE YOU:					
Presently being treated for any other illness?	<input type="checkbox"/>	<input type="checkbox"/>			
Taking medication for weight management	<input type="checkbox"/>	<input type="checkbox"/>			
Often exhausted or fatigued?	<input type="checkbox"/>	<input type="checkbox"/>			
A smoker or smoked previously?	<input type="checkbox"/>	<input type="checkbox"/>			

NAME: _____

Dental Conditions

What are your present dental concerns?

Have you avoided regular dental care?

On a scale of 1 (none) to 10 (worst), please rate any dental pain you are currently experiencing?

1 2 3 4 5 6 7 8 9 10

Do you have a history of:

Gum Disease

Abscess

Sores (Ulcers)

Grinding Teeth

Clicking or Popping in the Jaw

Sensitivities

Persistent Bad Breath

Cold Sores/Fever Blisters

Pain in Jaw Joint

Patient Signature: _____ Doctor Signature: _____

Date: _____