

### Patient Information and Medical History

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
(Prefer to be called) \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Work Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Male:  Female:

Marital Status:  Single  Married  Divorced  Widowed

Hobbies: \_\_\_\_\_

Spouse: Name: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Work Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_

#### Dental Insurance:

Primary Carrier Insurance Company: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Employee: \_\_\_\_\_ SS#: \_\_\_\_\_

Group #: \_\_\_\_\_ Phone#: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Employee: \_\_\_\_\_ SS#: \_\_\_\_\_

Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Dental Health:  Excellent  Good  Fair  Poor

What priority do you give your teeth? (10 being the highest) 1 2 3 4 5 6 7 8 9 10

Are your teeth completely comfortable?  Yes  No

If not please explain \_\_\_\_\_

Do you like your smile? \_\_\_\_\_

Do you grind or clench your teeth? \_\_\_\_\_

Do your jaw joints click, pop or cause pain? \_\_\_\_\_

Reason for your visit? \_\_\_\_\_

\_\_\_\_\_

**Medical Health:**  Excellent       Good       Fair       Poor

Physicians Name: \_\_\_\_\_

Date of Last Physical: \_\_\_\_\_ Are you under a doctor's care now? \_\_\_\_\_

If yes, for what reason: \_\_\_\_\_

Please list any medications or drugs you are taking: \_\_\_\_\_

\_\_\_\_\_

Do you need to pre-medicate before dental appointments?  Yes  No

Please list any vitamins or herbs you are taking: \_\_\_\_\_

Are you pregnant?  Yes  No How long? \_\_\_\_\_

Do you smoke?  Yes  No How many packs per day? \_\_\_\_\_

Soda consumption per day \_\_\_\_\_ Candy consumption per day \_\_\_\_\_

Are you allergic to:  Penicillin       Latex       Local Anesthetic       Other Meds

\_\_\_\_\_

**Do you have or have you had any of the following:**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Heart trouble           | <input type="checkbox"/> Shortness of breath         | <input type="checkbox"/> Frequent cough      | <input type="checkbox"/> Prostate          |
| <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Swelling: feet/ankles/hands | <input type="checkbox"/> Lung disease        | <input type="checkbox"/> Epilepsy          |
| <input type="checkbox"/> Low blood pressure      | <input type="checkbox"/> Fainting or dizziness       | <input type="checkbox"/> Liver disease       | <input type="checkbox"/> Alzheimer's       |
| <input type="checkbox"/> Heart murmur            | <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Hepatitis A         | <input type="checkbox"/> Psychiatric care  |
| <input type="checkbox"/> Rheumatic fever         | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Hepatitis B         | <input type="checkbox"/> Hemophilia        |
| <input type="checkbox"/> Congenital heart lesion | <input type="checkbox"/> Artificial joints           | <input type="checkbox"/> Hepatitis C         | <input type="checkbox"/> AIDS/HIV          |
| <input type="checkbox"/> Artificial heart valve  | <input type="checkbox"/> Kidney trouble              | <input type="checkbox"/> Recent weight loss  | <input type="checkbox"/> Blood transfusion |
| <input type="checkbox"/> Heart Pacemaker         | <input type="checkbox"/> Ulcers                      | <input type="checkbox"/> Cancer              |  |
| <input type="checkbox"/> Heart surgery           | <input type="checkbox"/> Allergies/Hay fever         | <input type="checkbox"/> Thyroid disease     |  |
| <input type="checkbox"/> Mitral valve prolapse   | <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Parathyroid disease |  |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Sinus trouble               | <input type="checkbox"/> Chemo/radiation     |  |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Emphysema                   | <input type="checkbox"/> Arthritis/gout      |  |
| <input type="checkbox"/> Chest pain              | <input type="checkbox"/> Hypoglycemia                | <input type="checkbox"/> Glaucoma            |  |

Have you ever had any other serious illness not listed above? If yes, please describe in detail:

\_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Has any member of your family been treated in our office previously? \_\_\_\_\_

Why did you choose Dr.Predmore as your dentist? \_\_\_\_\_

\_\_\_\_\_

**Authorization and Release:**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been answered accurately. Dr. Predmore may use and disclose my medical information for each of the following purposes: treatment, payment (insurance claims) and health care operations.

I will allow Dr. Predmore to photograph or videotape my dental conditions, treatment and procedures for educational purposes.

**Patient Signature** (or parent/guardian if minor): \_\_\_\_\_