

PATIENT INFORMATIONPatient's Name _____ Today's Date _____
Last First MiddleAddress _____
Street City State Zip

Residence Phone (____) _____ Business Phone (____) _____

Date of Birth _____ Male Female Single Married Separated Divorced Widowed

If patient is a minor, give parent's or guardian's name _____

FINANCIALLY RESPONSIBLE PARTY INFORMATIONFinancially Responsible Party's Name _____
Last First MiddleAddress _____
Street City State Zip

Residence Phone (____) _____ Business Phone (____) _____ Ext. _____

Date of Birth _____ Social Security No. _____ Driver's License No. _____

Relationship to Patient _____

Employer _____ Occupation _____

Business Address _____
Street City State ZipSpouse's Name _____
Last First Middle

Date of Birth _____ Social Security No. _____ Driver's License No. _____

Employer _____ Occupation _____

Business Address _____
Street City State Zip**INSURANCE INFORMATION****Primary**Insured's Name _____ Insured's Soc. Sec. No. _____
Last First Middle

Insured's Date of Birth _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____
Street City State ZipDo you have dual coverage? Yes No **If yes;****Secondary**Insured's Name _____ Insured's Soc. Sec. No. _____
Last First Middle

Insured's Date of Birth _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____
Street City State Zip**Financial Terms and Conditions:** Financial arrangements must be made prior to treatment. All Emergency Dental Services rendered without previous financial arrangements must be paid in full at the time services are performed. If you have Dental Insurance, our office will help prepare your claim and have reimbursements sent to the insured. (Our dental office will not render services on the assumption that expense incurred will be paid by an insurance company).

Signature _____ Date _____

Patient's Name _____ Date of Birth _____ Today's Date _____

For what condition have you sought a dental evaluation? _____

Whom may we thank for referring you to our office? _____

Please complete the following important questions by circling yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Dental

1. Have you ever had any serious trouble associated with previous dental treatment? Yes No

If so, explain _____

2. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____

3. Date of last dental visit _____

4. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No

If so, when? _____

5. How often do you brush? _____

6. How often do you use dental floss? _____

Brush is: Soft Medium Hard

7. Do you have or have you ever had any of the following:

Mouth

Teeth

- Bleeding, sore gums Yes No
- Unpleasant taste/bad breath Yes No
- Burning tongue/lips Yes No
- Frequent blisters, lips/mount Yes No
- Swelling/lumps in mouth Yes No
- Ortho treatments (braces) Yes No
- Biting cheeks/lips Yes No
- Clicking/popping jaw Yes No
- Difficulty opening or closing jaw Yes No

- Loose teeth Yes No
- Sensitive to hot Yes No
- Sensitive to cold Yes No
- Sensitive to sweets Yes No
- Sensitive to biting Yes No
- Food impaction Yes No
- Clenching/grinding Yes No
- If so, when? _____
- Shifting in bite Yes No
- Change in bite Yes No

8. Do you have?:

- Upper Denture Yes No Age of Denture _____ Upper Bridge Yes No Age of Bridge _____
- Lower Denture Yes No Age of Denture _____ Lower Bridge Yes No Age of Bridge _____
- Upper Partial Yes No Age of Partial _____ Upper Crowns Yes No Age of Crowns _____
- Lower Partial Yes No Age of Partial _____ Lower Crowns Yes No Age of Crowns _____

Name of general dentist _____ Phone No. (____) _____
Name of additional dentist(s) _____ Phone No. (____) _____
_____ Phone No. (____) _____

Medical

Name of current physician(s) _____ Phone No. (____) _____
_____ Phone No. (____) _____
_____ Phone No. (____) _____

- 1. Has there been any change in your general health within the past year? Yes No
- 2. My last physical examination was on _____
- 3. Are you under the care of a physician? Yes No
If so, what is the condition being treated? _____
- 4. Have you had any serious illness within the past five (5) years? Yes No
If so, what was the illness? _____
- 5. Have you been hospitalized or had an operation within the past five (5) years? Yes No
If so, what was the problem? _____

6. Do you have or have you had any of the following diseases or problems?
- | | | |
|--|-----|----|
| a. Rheumatic fever or rheumatic heart disease | Yes | No |
| b. Congenital heart disease <input type="checkbox"/> Heart murmur <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Regurgitations | Yes | No |
| c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.) | Yes | No |
| 1) Do you have pain in chest upon exertion? | Yes | No |
| 2) Are you short of breath after mild exercise? | Yes | No |
| 3) Do your ankles swell? | Yes | No |
| 4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep? | Yes | No |
| d. Artificial or replacement valves | Yes | No |
| e. Pacemaker | Yes | No |
| f. Allergy | Yes | No |
| g. Sinus trouble | Yes | No |
| h. Asthma or hay fever | Yes | No |
| i. Hives or a skin rash | Yes | No |
| j. Fainting spells or seizures | Yes | No |
| k. Diabetes | Yes | No |
| 1) Do you have to urinate (pass water) more than six times a day? | Yes | No |
| 2) Are you thirsty much of the time? | Yes | No |
| 3) Does your mouth frequently become dry? | Yes | No |
| l. Hepatitis, jaundice or liver disease | Yes | No |
| m. Arthritis or inflammatory rheumatism | Yes | No |
| n. Artificial or replacement joints, prosthetic | Yes | No |
| o. Digestive system – Ulcers or stomach disorders (colitis) | Yes | No |
| p. Kidney trouble | Yes | No |
| q. Tuberculosis | Yes | No |
| r. Persistent cough or cough up blood | Yes | No |
| s. Immune system disorder (including AIDS, HIV, ARC) | Yes | No |
| t. Venereal disease | Yes | No |
| u. Other _____ | | |
7. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?
- | | | |
|---|-----|----|
| 7. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? | Yes | No |
| 8. Do you bruise easily? | Yes | No |
| 9. Have you ever required a blood transfusion? | Yes | No |
- If so, explain the circumstances & when _____
10. Have you ever tested **POSITIVE** for the AIDS virus?
- | | | |
|--|-----|----|
| 10. Have you ever tested POSITIVE for the AIDS virus? | Yes | No |
| 11. Do you have any blood disorder such as anemia? | Yes | No |
| 12. Have you had surgery or x-ray treatment for a tumor, growth, or other condition? | Yes | No |
| 13. What implants, if any, do you have? _____ | | |
14. Are you taking any of the following?:
- | | | |
|--|-----|----|
| a. Antibiotics or sulfa drugs | Yes | No |
| b. Anticoagulant (blood thinners) | Yes | No |
| c. Medicine for high blood pressure | Yes | No |
| d. Cortisone (steroids) | Yes | No |
| e. Tranquilizers | Yes | No |
| f. Antihistamines | Yes | No |
| g. Aspirin | Yes | No |
| h. Insulin, tolbutamide (Orinase) or similar drug for diabetes | Yes | No |
| i. Digitalis or drugs for heart trouble | Yes | No |
| j. Nitroglycerin | Yes | No |
| k. Other medications _____ | | |
| l. If "Yes" to any of the above, state drug name, dosage and frequency _____ | | |
15. Do you need to take premedication for dental procedures?
- | | | |
|--|-----|----|
| 15. Do you need to take premedication for dental procedures? | Yes | No |
|--|-----|----|
16. Are you allergic or have you reacted adversely to?:
- | | | |
|---|-----|----|
| a. Local anesthetics | Yes | No |
| b. Penicillin or other antibiotics | Yes | No |
| c. Sulfa drugs | Yes | No |
| d. Barbiturates, sedatives, or sleeping pills | Yes | No |
| e. Aspirin | Yes | No |
| f. Iodine | Yes | No |
| g. Codeine or narcotics | Yes | No |
| h. Other _____ | | |

17. What dietary supplements have you taken? i.e. Ephedrine, Phen-Fen, _____
18. Do you use any tobacco products? Yes No
If so, how much per day and what _____
19. Do you use any alcohol products? Yes No
If so, how much per day/week/month and what _____
20. Do you use any caffeinated products (coffee, tea, chocolate, etc.)? Yes No
If so, how much per day and what _____
21. Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No
If so, explain _____
22. Are you employed in any situation which exposes you regularly to x-rays or other ioning radiation? Yes No
23. Are you wearing contacts? Yes No
24. Are you experiencing stress or pressure in your work or at home? Yes No

Women

25. Is there a possibility you could be pregnant? Yes No
26. Do you have PMS or problems associated with your menstrual period? Yes No
27. Are you taking birth control or hormone therapy? Yes No
28. Name and phone number of your physician _____ (_____) _____

Emergency Information

Name of nearest relative not living with you _____ Relationship _____
Address _____ Phone No. (_____) _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Christopher P. Travis, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form. If I ever have any change in my health or in my medication I will inform Dr. Christopher P. Travis.

Patient's Signature _____ Date _____
(Parent's or Guardian's if Patient is a Minor)

For Completion by the Dentist

Comments on patient interview concerning medical history _____

Significant findings from questionnaire or oral interview _____

Dental management considerations _____

Medical History Update

Date _____ Comments _____
Date _____ Comments _____
Date _____ Comments _____
Date _____ Comments _____
Date _____ Comments _____