PATIENT INFORMATION

Patient Name: _____ Patient #:_____ Date:_____
Last First M

Address: _____
Street Apt# City State Zip

Birth date: _____/_____/_____ Telephone: Home: _____ Work:_____ Cell:_____

Height:_____ Weight:_____ Sex: ☐ M ☐ F Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated

If Student, _____ ☐ Full Time ☐ Part Time
Name of School/College City State Grade

Patient's Employer:_____ Occupation:_____ SS#:_____

Business Address: _____
Street Suite# City State Zip

Spouse Name: _____ Employer: _____ Work Phone: _____

Person to contact in case of emergency: _____ Relationship:_____ Phone: _____

If you are completing this form for another person, what is your relationship to that person? _____

Whom may we thank for referring you to our office? _____ E-mail: _____

Name of Person Responsible for this Account: _____ Relationship to Patient: _____

Address (if different from above): _____ City:_____ State:____ Zip:_____

Birth date: _____/_____/_____ Telephone: Home: _____ Work:_____

SS#: _____ Drivers License #:_____

Primary Dental Coverage Information **If you do not have primary coverage, please check this box:** ☐

Name of Insured: _____ Relationship to Patient:_____ Birth date: _____/_____/_____

Address (if different from above): _____ City:_____ State:____ Zip:_____

SS#: _____ Drivers License #:_____ Date Employed: _____/_____/_____

Name of Employer: _____ Union/Local #: ___ Telephone: Work:_____ Home:_____

Address of Employer: _____ City:_____ State:____ Zip:_____

Dental Ins. Company:_____ Group #:_____ Policy/ID #:_____

Secondary Dental Coverage Information **If you do not have secondary coverage, please check this box:** ☐

Name of Insured: _____ Relationship to Patient:_____ Birth date: _____/_____/_____

Address (if different from above): _____ City:_____ State:____ Zip:_____

SS#: _____ Drivers License #:_____ Date Employed: _____/_____/_____

Name of Employer: _____ Union/Local #: ___ Telephone: Work:_____ Home:_____

Address of Employer: _____ City:_____ State:____ Zip:_____

Dental Ins. Company:_____ Group #:_____ Policy/ID #:_____

DENTAL HISTORY

Please answer each question by circling Yes or No.

Do you have a specific dental problem of chief complaint? Describe: _____ Yes No

Do you have dental examinations on a routine basis? When was your last visit? _____ Yes No

Do you think you have cavities or gum disease? _____ Yes No

Do you brush and floss on a routine basis? Describe: _____ Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No

Do your gums ever bleed? Describe: _____ Yes No

Do you like your smile? Why: _____ Yes No

Do you want to keep your remaining teeth? _____ Yes No

Have your past experiences in a dental office been positive? _____ Yes No

Name of previous dentist: _____ Date of last full mouth x-ray series: _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Date: _____ Signature: _____
(if patient is a minor, include printed name and signature of parent or legal guardian)

DO NOT WRITE IN THIS SPACE

DATE: _____ REVIEWED BY: _____ DENTIST'S COMMENTS: _____

HEALTH HISTORY

Patient Name: _____ Patient #:_____ Date:_____
Last First M

Please answer each question by checking the appropriate box or circling Yes or No.

1. Are you in good health?..... Yes No
2. Date of last physical examination: _____
3. Are you now under the care of a physician? ..... Yes No
   If yes, what is the condition being treated?
   Doctor's name: _____ Telephone #:_____
4. Have you ever had any serious illness or been hospitalized?..... Yes No
   Please Explain: _____
5. Are you taking any medication? ..... Yes No
   If yes, what? _____
6. Are you using any recreational drugs (e.g., marijuana, cocaine) or controlled substance?..... Yes No
   If yes, what? _____
7. Have you ever been pre-medicated with antibiotics for you dental treatment?..... Yes No
8. Are you sensitive or allergic to any drugs or materials? ☐ Penicillin ☐ Tetracycline ☐ Erythromycin ☐ Aspirin
   ☐ Codeine ☐ Latex ☐ Other If Other, please explain: _____
9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No – Answer all conditions:

☐Y ☐N AIDS	☐Y ☐N Cortisone Medicine	☐Y ☐N Hemophilia	☐Y ☐N Respiratory Disease
☐Y ☐N Allergies or Hives	☐Y ☐N Diabetes	☐Y ☐N Hepatitis or Jaundice	☐Y ☐N Rheumatic Fever
☐Y ☐N Allergies to Metals	☐Y ☐N Difficulty Swallowing	☐Y ☐N Herpes	☐Y ☐N Rheumatism
☐Y ☐N Anemia	☐Y ☐N Drug Addiction	☐Y ☐N High Blood Pressure	☐Y ☐N Sickle Cell Disease
☐Y ☐N Angina Pectoris	☐Y ☐N Emphysema	☐Y ☐N HIV Positive	☐Y ☐N Sinus Trouble
☐Y ☐N Arthritis	☐Y ☐N Epilepsy or Seizures	☐Y ☐N Joint Replacement	☐Y ☐N Stomach Ulcers
☐Y ☐N Artificial Heart Valve	☐Y ☐N Excessive Bleeding	☐Y ☐N Kidney Disease	☐Y ☐N Stroke
☐Y ☐N Asthma	☐Y ☐N Fainting Spells / Seizures	☐Y ☐N Liver Disease	☐Y ☐N TMJ
☐Y ☐N Blood Disease	☐Y ☐N Glaucoma	☐Y ☐N Mental Disorder	☐Y ☐N Thyroid Disease
☐Y ☐N Blood Transfusion	☐Y ☐N Hay Fever	☐Y ☐N Mitral Valve Prolapse	☐Y ☐N Tonsillitis
☐Y ☐N Bruise Easily	☐Y ☐N Head Injuries	☐Y ☐N Nervous Disorders	☐Y ☐N Tuberculosis
☐Y ☐N Chemotherapy	☐Y ☐N Heart Ailments or Attack	☐Y ☐N Pain in Jaw Joints	☐Y ☐N Tumors or Growths
☐Y ☐N Cold Sores	☐Y ☐N Heart Failure	☐Y ☐N Psychiatric Treatment	☐Y ☐N Venereal Disease
☐Y ☐N Congenital Heart Lesions	☐Y ☐N Heart Murmur	☐Y ☐N Radiation Therapy	

10. Do you wear a cardiac pacemaker, or have you had heart surgery? If yes please explain:_____ ..... Yes No
11. Do you smoke, chew, use snuff or any other forms of tobacco? ☐ Cigarettes ☐ Cigars ☐ Chew ☐ Snuff ☐ Other... Yes No
    If yes, how much? _____
12. Do you consume alcoholic beverages? If yes how much? _____ ..... Yes No
13. Have you ever taken the drug "Fen-Phen" or "Redux"?..... Yes No
14. Are you pregnant? If yes how many months? _____ ..... Yes No
15. Do you have any problems associated with your menstrual period?..... N/A Yes No
16. Do you take birth control pills?..... N/A Yes No
17. Is there anything we should know about your health that is not mentioned above? ..... Yes No
    Please explain: _____

1st **I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.**

Date: _____ Signature: _____
(if patient is a minor, include printed name and signature of parent or legal guardian)

2nd ***UPDATE*** *– Since your last visit:*

1. Have you seen a medical doctor?..... Yes No
2. Have you had a change in medication?..... Yes No
3. Have you had a change in any medical condition or had surgery?..... Yes No

If yes, please explain:_____

Date: _____ Signature: _____

3rd ***UPDATE*** *– Since your last visit:*

1. Have you seen a medical doctor?..... Yes No
2. Have you had a change in medication?..... Yes No
3. Have you had a change in any medical condition or had surgery?..... Yes No

If yes, please explain:_____

Date: _____ Signature: _____

Patient Responsible for Fees & Assignment of Insurance Benefits: I understand that responsibility for payment for Dental Services provided in this office for myself or for my dependents is mine. Unless prior special arrangements are made, accounts are to be paid on the date which services are provided. I hereby authorize that the payments from any insurance company due me be paid directly to this office. In the event of default in my payment, patient or party responsible for fees agrees to pay any and all cost of suit, collection and attorney's fees.

Patient or Guardian Signature: _____ Date: _____