PATIENT INFORMATION and DENTAL HISTORY

Patient Name _____ Preferred name_____
Last First Middle Initial

Residence _____
Street Address City Zip

Home/Cell Phone _____ If less than one year at current address, give former address below:

_____
Street Address City State Zip

Patient's Date of Birth _____ Height_____ Weight _____ Marital Status _____

If patient is a minor: Guardian's Name _____ Relationship _____

Patient or Guardian's Employer _____ Business Phone _____

Business Address_____
Street Address City State Zip

(If married) Spouse's Name _____ Employer _____ Business Phone _____

(If student) School name _____ Grade _____ Interest/activities _____

Who Referred You to our Office? _____ ☐ Friend, family, other dentist ☐ Yellow pages
☐ Newspaper ☐ Internet ☐ Direct mailing

Responsible Party

Person Responsible for This Account _____ Relationship to patient _____

Driver's License#_____ State _____ Birthday _____ Employer _____

Dental Insurance Information

Name of Primary Insured_____ Relationship to Patient _____

Birthday _____ Social Security # _____ Date Employment Started _____

Address of Employer _____ Work Phone _____

Insurance Company _____ Group # _____ Insurance Co. Phone _____

Insurance Company Mailing Address_____

Dental History **Indicate (check) which of the following conditions apply:**

___ Unhappy with appearance of my smile
___ Want straighter teeth
___ Want whiter teeth
___ Tired or sore jaws after talking or eating
___ Problems with past dental care
___ Clench or grind your teeth during the day___ night ___
___ TMJ or jaw joint damage
___ Food catches between your teeth
___ Fear dental treatment
___ Want nitrous oxide treatment visits
___ Pain when biting or chewing
___ Bleeding or receding gums or mouth odor
___ Want to be sedated Oral _____ IV _____
___ Pain to Heat ____ Cold ____

If you could change anything about your mouth what would be most important?_____

_____

What would you like to change about your teeth or smile? _____

_____

What is the reason for your visit today? _____

Why did you choose our office? _____

Is there anything else you would like to know about our office? _____

By signing below I certify this information is accurate and give consent for treatment.

Signature of Patient, Parent, or Guardian _____ Date _____

PATIENT MEDICAL HISTORY

1. How would you describe your current health status ? Excellent Good Fair Poor
2. List your physician(s) and any conditions you are being treated for:

Dr. _____ Treating you for _____ How long _____
Dr. _____ Treating you for _____ How long _____
Dr. _____ Treating you for _____ How long _____

3. Date of last physical examination _____ Purpose _____ Findings _____
4. List ALL medicines or nutritional supplements, including over the counter medicine, you are currently taking:

_____
_____

Circle "Yes" or "No"		**Explain or list all Yes answers**
5. Are you on a special or restricted diet of any kind?	No	Yes_____
6. Are you allergic to any medications?	No	Yes_____
7. Do you smoke or use tobacco in any form? How long _____	No	Yes_____
8. Have you been hospitalized within the past 2 years?	No	Yes_____
9. If female, are you pregnant or taking birth control pills?	No	Yes_____
10. Do you have more than one alcoholic drink a day?	No	Yes_____
11. Has your health changed in the last 12 months?	No	Yes_____

Indicate (check) which of the following conditions you have ever had or been treated for:

___ Heart disease or attack*_____
___ Heart trouble*_____
___ Pacemaker*_____
___ Artificial Heart valve*_____
___ Excessive bleeding*_____
___ High blood pressure* _____
___ Stroke* _____
___ Anemia*_____
___AIDS* _____
___ Drug or alcohol addiction* _____
___ Psychiatric care* _____
___ Artificial joint* _____
___ Glaucoma* _____
___ Contact lenses* _____

___ Kidney problems*_____
___ Emphysema*_____
___ COPD*_____
___ Asthma*_____
___ Tuberculosis*_____
___Diabetes*_____
___Epilepsy or seizures*_____
___Cancer or tumor*_____
___Radiation therapy*_____
___Arthritis*_____
___Ulcers*_____
___Venereal disease*_____
___Liver disease*_____
___Hepatitis*_____

Explain ANY health problems not listed above? _____

By signing below I certify that to the best of my knowledge, all of the above answers are true and correct. If I ever have any changes in my health, I will inform the doctor or office before my next visit.

Signature of Patient, Parent, or Guardian _____ Date _____