Patient Name _____ Today's Date _____
Home Address _____ Date Of Birth _____
_____ Home Phone _____
Business Address _____ Business Phone _____
_____ Soc. Sec. No. _____

PATIENT NAME

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date Of Last Exam _____

Yes No
❒ ❒ 1. Are You Under Medical Treatment Now?
❒ ❒ 2. Have You Ever Been Hospitalized For Any Surgical Operation Or Serious Illness?
❒ ❒ 3. Are You Taking Any Medication/s Including Non-Prescription Medicine? If Yes, What Medications Are You Taking?
_____
_____
_____
❒ ❒ 4. Do You Use Tobacco?
❒ ❒ 5. Do You Use Alcohol, Cocaine Or Other Drugs?
❒ ❒ 6. Are You Wearing Contact Lenses?
7. Are You Allergic To Or Have You Had Reactions To The Following:
❒ ❒ ..... Local Anesthetics (Eg. Novocaine)
❒ ❒ ..... Penicillin Or Other Antibiotics
❒ ❒ ..... Sulfa Drugs
❒ ❒ ..... Barbiturates
❒ ❒ ..... Sedatives
❒ ❒ ..... Iodine
❒ ❒ ..... Aspirin
❒ ❒ ..... Other _____
8. Women Only:
❒ ❒ Are You Pregnant Or Think You May Be Pregnant?
❒ ❒ Are You Nursing?
❒ ❒ Are You Taking Birth Control Pills?

Yes No 9. Do You Have Or Have You Had Any Of The Following?
❒ ❒ .....High Blood Pressure
❒ ❒ .....Heart Attack
❒ ❒ .....Rheumatic Fever
❒ ❒ .....Swollen Ankles
❒ ❒ .....Fainting/Seizures
❒ ❒ .....Asthma
❒ ❒ .....Low Blood Pressure
❒ ❒ .....Epilepsy/Convulsions
❒ ❒ .....Leukemia
❒ ❒ .....Diabetes
❒ ❒ .....Kidney Diseases
❒ ❒ .....Aids Or HIV Infection
❒ ❒ .....Thyroid Problem
❒ ❒ .....Heart Disease
❒ ❒ .....Cardiac Pacemaker
❒ ❒ .....Heart Murmur
❒ ❒ .....Angina
❒ ❒ .....Frequently Tired
❒ ❒ .....Anemia
❒ ❒ .....Emphysema
❒ ❒ .....Cancer
❒ ❒ .....Arthritis
❒ ❒ .....Joint Replacement Or Implant
❒ ❒ .....Hepatitis/Jaundice
❒ ❒ .....Sexually Transmitted Disease
❒ ❒ .....Stomach Troubles / Ulcers

Yes No
❒ ❒ .....Chest Pains
❒ ❒ .....Easily Winded
❒ ❒ .....Stroke
❒ ❒ .....Hay Fever / Allergies
❒ ❒ .....Tuberculosis
❒ ❒ .....Radiation Therapy
❒ ❒ .....Glaucoma
❒ ❒ .....Recent Weight Loss
❒ ❒ .....Liver Disease
❒ ❒ .....Heart Trouble
❒ ❒ .....Respiratory Problems
❒ ❒ .....Other _____
_____
_____

COMMENTS

_____
Signature Of Dentist Date

PATIENT DENTAL HISTORY

Yes No
❒ ❒ 1 Do Your Gums Bleed While Brushing Or Flossing?
❒ ❒ 2. Are Your Teeth Sensitive To Hot Or Cold Liquids/Foods?
❒ ❒ 3. Are Your Teeth Sensitive To Sweet Or Sour Liquids/Foods?
❒ ❒ 4. Do You Feel Pain To Any Of Your Teeth?
❒ ❒ 5. Do You Have Any Sores Or Lumps In Or Near Your Mouth?
❒ ❒ 6. Have You Had Any Head, Neck Or Jaw Injuries
7. Have You Ever Experienced Any Of The Following Problems In Your Jaw?
❒ ❒ ..... Clicking
❒ ❒ ..... Pain in Joint, Ear, Side Of Face?
❒ ❒ ..... Difficulty In Opening Or Closing?
❒ ❒ ..... Difficulty In Chewing?

Yes No
❒ ❒ 8. Do You Have Frequent Headaches?
❒ ❒ 9. Do You Clench Or Grind Your Teeth?
❒ ❒ 10. Do You Bite Your Lips Or Cheeks Frequently?
❒ ❒ 11. Have You Ever Had Any Difficult Extractions In The Past?
❒ ❒ 12. Have You Had Any Orthodontic Work?
❒ ❒ 13. Have You Ever Had Prolonged Bleeding Following Extractions?
❒ ❒ 14. Have You Ever Had Instruction On The Correct Method Of Brushing Your Teeth?
❒ ❒ 15. Have You Ever Had Instructions On The Care Of Your Gums?

SIGNATURE

I Certify That I Have Read And Understand The Above Information. To The Best Of My Knowledge, The Above Questions Have Been Accurately Answered. I Understand That Providing Incorrect Information Can Be Dangerous To My Health.

Signature of Patient, Parent Or Guardian X _____ Date _____

PATIENT # _____

DATE _____

PATIENT INFORMATION-CONFIDENTAIL

Last Name _____ First Name _____ Middle Initial _____ Birthdate _____

Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

E-Mail _____

Check Appropriate Box: ❒Minor ❒Single ❒Married ❒Divorced ❒Widowed ❒Separated

Patient's Or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse Or Parent/Guardian's Name _____

Employer _____ Work Phone _____

If Patient Is A Student, Name Of School/College _____ City/State _____

Whom May We Thank For Referring You? _____

Person To Contact In Case Of An Emergency _____ Phone _____

RESPONSIBLE PARTY

Name Of Person Responsible For This Account _____ Relationship To Patient _____

Address _____ Home Phone _____ Cell Phone _____

E-Mail _____ Birthdate _____

Employer _____ Work Phone _____

Driver's License # _____ Financial Institution _____

Is This Person Currently A Patient In Our Office? ❒ Yes ❒ No

INSURANCE INFORMATION

Name Of Insured _____ Relationship To Patient _____

Birthdate _____ SS# _____ Date Employed _____

Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union Or Local # _____

Insurance Company Address _____ City _____ State _____ Zip _____

How Much Is Your Deductible? _____ How Much Have You Used? _____ Max Annual Benefit? _____

Do You Have Any Additional Insurance? ❒ No ❒ Yes If Yes, Complete The Following:

Name Of Insured _____ Relationship To Patient _____

Birthdate _____ SS# _____ Date Employed _____

Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union Or Local # _____

Insurance Company Address _____ City _____ State _____ Zip _____

How Much Is Your Deductible? _____ How Much Have You Used? _____ Max Annual Benefit? _____

SIGNATURE

X _____ Signature Of Patient Or Parent/Guardian If Minor