Patient Information (Confidential)

Name_____ Home Phone_____ SSN_____

By what name would you like to be called? _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Email _____

Circle: Male Female Circle: Married Single Divorced Widowed Separated

Employer _____ Business Address _____

Work Phone _____ Ext. _____ Hours _____ Can you receive calls at work? Yes No

Spouse Name _____ Whom may we thank for referring you?_____

If patient is a student, name of school _____

Person to contact in case of emergency _____ Phone _____

Are any members of your family patients of this practice? _____ Relationship _____

Responsible Party Name of person responsible for this account _____

SSN _____ Relationship to patient _____

Address _____ Phone_____

Employer _____ Work Phone _____ Ext._____

Dental Insurance Information

Name of Insured _____ Relationship to patient _____ Date of birth _____

SSN _____ Employer _____ Work Phone _____ Ext____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Address _____ City _____ State _____ Zip_____

Ins. Co. Phone No. _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefits?_____

Do you have additional dental insurance? Yes___ No___ If yes, please complete the following:

Name of Insured _____ Relationship to patient _____ Date of birth _____

SSN _____ Employer _____ Work Phone _____ Ext____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Address _____ City _____ State _____ Zip_____

Ins. Co. Phone No. _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefits?_____

Medical History

Patient Name _____

1. Have you been under the care of a medical doctor during the past two years?.....Yes No
   If yes, for what? _____
   Physician's name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
2. Have you taken any medications or drugs during the past two years?.....Yes No
3. Are you taking any medication, drugs, or pills now?..... Yes No
   If yes, list name and dosage _____
4. Have you ever had an allergic or adverse reaction to any medication or substance?.....Yes No
   If yes, please list _____
5. Have you been a patient in a hospital during the past five years?.....Yes No
6. Indicate which of the following you have had or have at present? Circe "Yes" or "No" to each item.

Heart (surgery, disease, attack)…	Yes	No	Latex allergy….....	Yes	No
Chest pain…….....	Yes	No	Allergies or hives….....	Yes	No
Congenital heart disease…..…...	Yes	No	Sinus trouble….....	Yes	No
Artificial heart valve…….....	Yes	No	Radiation therapy.....…	Yes	No
High Blood Pressure.....…..…	Yes	No	Chemotherapy….....	Yes	No
Arthritis/ Rheumatism……..…..	Yes	No	Tumors….....	Yes	No
Cortisone medicine……..……..…	Yes	No	Hepatitis.....…	Yes	No
Swollen ankles…….....	Yes	No	Venereal disease.....…	Yes	No
Stroke.....	Yes	No	AIDS….....	Yes	No
Diet (special/restricted).....…	Yes	No	HIV positive….....	Yes	No
Artificial joints (hip, knee, etc.).....…	Yes	No	Cold sores/ Fever blisters.....…	Yes	No
Osteoporosis.....…	Yes	No	Blood transfusion.....…	Yes	No
Kidney trouble.....…	Yes	No	Hemophilia.....	Yes	No
Ulcers.....…	Yes	No	Sickle Cell Disease.....…	Yes	No
Diabetes.....…	Yes	No	Bruise easily….....	Yes	No
Thyroid problems.....…	Yes	No	Liver disease.....…	Yes	No
Glaucoma.....…	Yes	No	Yellow jaundice.....…	Yes	No
Contact lenses.....…	Yes	No	Neurological disorders.....…	Yes	No
Emphysema.....…	Yes	No	Epilepsy or Seizures….....	Yes	No
Chronic cough.....…	Yes	No	Fainting or dizzy spells….....	Yes	No
Tuberculosis.....…	Yes	No	Nervous/ Anxious….....	Yes	No
Asthma.....…	Yes	No	Psychiatric/ Psychological care…...	Yes	No
Hay fever.....…	Yes	No	Chemical dependency/ addiction..	Yes	No

7. Do you have or have you had any condition not listed? .....Yes No
   If yes, please list _____
8. Women, are you: **Pregnant**? Yes No If yes, how many months?___ **Nursing**? Yes No **On Birth Control Pills**? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

*Patient/ Guardian Signature:*_____ *Date* _____

History Review:

Dental History

Patient Name _____

What is the reason for your visit today?_____
_____

Date of last dental visit_____ **Last dental cleaning**_____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____
_____

Dentist's Name _____
Address _____ **City** _____ **State**____ **Zip** _____
Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ **How often do you floss?** _____
What other dental aids do you use? (Interdental brush, toothpick, etc.) _____
Do you have any dental problems now? Yes No If yes, please describe _____
_____

Are any of your teeth sensitive to:
Hot or Cold?..... Yes No
Sweets?..... Yes No
Biting or Chewing? ..... Yes No
Have you noticed any mouth odors or bad tastes?... Yes No
Do you frequently get cold sores, blisters or any other oral lesions?..... Yes No
Do your gums bleed or hurt?..... Yes No
Have your parents experienced gum disease or tooth loss?..... Yes No
Have you noticed any loose teeth or changes in your bite?..... Yes No
Does food tend to get caught between your teeth?..... Yes No

Do you:
Clench or grind your teeth while awake or asleep?..... Yes No
Bite your lips or cheeks regularly?..... Yes No
Hold foreign objects with your teeth?..... Yes No
(pencils, pipe, pins, nails, fingernails)
Mouth breathe while awake or asleep?..... Yes No
Have tired jaws, especially in the morning?..... Yes No
Smoke or chew tobacco?..... Yes No

Have you ever had:
Orthodontic treatment?..... Yes No
Oral surgery?..... Yes No
Periodontal treatment?..... Yes No
A bite splint or mouth guard?..... Yes No
A serious injury to your mouth or head?..... Yes No
If so, please describe_____
_____

Have you experienced:
Clicking or popping of the jaw?..... Yes No
Pain? (joint, ear, side of face) .... Yes No
Difficulty in opening or closing the mouth? .... Yes No
Headaches, neck aches or shoulder aches?..... Yes No
Sore muscles? (neck, shoulders)..... Yes No

Are you satisfied with the appearance of your teeth?..... Yes No
If no, please explain_____
_____
Would you like us to discuss ways we can improve the appearance of your teeth?..... Yes No

Is keeping your teeth all of your life important to you?..... Yes No

Do you feel nervous about having dental treatment?..... Yes No
If so, what is your biggest concern? _____
_____

Have you ever had an upsetting dental experience?..... Yes No
If so, please explain _____
_____

Is there anything else about having dental treatment that you would like us to know?..... Yes No
If yes, please describe _____