

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:**

- | | |
|--|--|
| <input type="checkbox"/> Unhappy with appearance of my smile | <input type="checkbox"/> Food catches between your teeth |
| <input type="checkbox"/> Want straighter teeth | <input type="checkbox"/> Fear dental treatment |
| <input type="checkbox"/> Want whiter teeth | <input type="checkbox"/> Want nitrous oxide treatment visits |
| <input type="checkbox"/> Tired or sore jaws after talking or eating | <input type="checkbox"/> Pain when biting or chewing |
| <input type="checkbox"/> Problems with past dental care | <input type="checkbox"/> Bleeding or receding gums or mouth odor |
| <input type="checkbox"/> Clench or grind your teeth during the day ___ night ___ | <input type="checkbox"/> Want to be sedated Oral ___ IV ___ |
| <input type="checkbox"/> TMJ or jaw joint damage | <input type="checkbox"/> 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? No Yes _____
- How long _____
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* _____ | ____ Kidney problems* _____ |
| ____ Heart trouble* _____ | ____ Emphysema* _____ |
| ____ Pacemaker* _____ | ____ COPD* _____ |
| ____ Artificial Heart valve* _____ | ____ Asthma* _____ |
| ____ Excessive bleeding* _____ | ____ Tuberculosis* _____ |
| ____ High blood pressure* _____ | ____ Diabetes* _____ |
| ____ Stroke* _____ | ____ Epilepsy or seizures* _____ |
| ____ Anemia* _____ | ____ Cancer or tumor* _____ |
| ____ AIDS* _____ | ____ Radiation therapy* _____ |
| ____ Drug or alcohol addiction* _____ | ____ Arthritis* _____ |
| ____ Psychiatric care* _____ | ____ Ulcers* _____ |
| ____ Artificial joint* _____ | ____ Venereal disease* _____ |
| ____ Glaucoma* _____ | ____ Liver disease* _____ |
| ____ Contact lenses* _____ | ____ 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** _____