

PATIENT INFORMATION AND HISTORY

Please Print



PATIENT INFORMATION

Date _____ SS# _____

Patient Name _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex M F Birthdate _____
 Married Widowed Single Minor Separated Divorced

Home (____) _____ Work (____) _____ Ext _____ Cell Phone (____) _____

Patient Employer/School _____ Occupation _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Spouse Work # (____) _____ Spouse Cell # (____) _____

If patient is a minor, who is legally responsible? _____

Address _____ City _____ State _____ Zip _____

In case of emergency contact—Name _____ Relationship _____

Home (____) _____ Work (____) _____ Ext _____ Cell Phone (____) _____

Whom may we thank for referring you? _____



DENTAL INSURANCE

Primary Insurance

Name of Insured _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____
If different from patient's

Phone (____) _____ Relationship to Patient _____

Employer _____

Business Address _____ Business Phone # (____) _____

Insurance Co. _____ Member ID # _____

Phone (____) _____ Group# _____

Secondary Insurance

Name of Insured _____ Birthdate _____ SS# _____

Relationship to Patient _____ Address _____ city _____ state _____ zip _____

Employer _____

Insurance Co. _____ Member ID # _____

Phone (____) _____ Group# _____



DENTAL HISTORY

Reason for today's visit _____	Burning sensation on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Chew on one side of mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Cigarette, pipe or cigar smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental xrays _____	Food collection between teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bad Breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tenderness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growth in your mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____	
	Loose teeth or broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____	



HEALTH HISTORY

Physicians Name _____ Date of last visit _____

Address _____ City/State _____ Phone# (____) _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eating Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autism Spectrum Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autoimmune Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Behavioral Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Please specify:</i>		Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormality, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other condition not listed:	

Have you had recent surgery or been hospitalized? Yes No

Please Specify: _____

Have you been told to pre-medicate for dental treatment? Yes No

Reason: _____

Women:

Are you pregnant? Yes No Due Date: _____

Are you nursing? Yes No

Are you taking birth control pills? Yes No



ALLERGIES

Codeine or other prescription painkillers Local Anesthetic Antibiotics—Please list: _____

Latex Other: _____



MEDICATIONS

Pharmacy Name _____ Phone: (____) _____

List any **MEDICATIONS** (prescription and over the counter, including vitamins/nutritional supplements) you are currently taking and the **REASON**

MEDICATIONS

REASON

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge and that it is my responsibility to inform this office of any changes in my/my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature _____ Date _____