PATIENT INFORMATION AND HEALTH HISTORY

DATE ____/____/____ REFERRED BY: _____

PLEASE PRINT CLEARLY, FILL OUT ALL BLANKS COMPLETELY AND ACCURATELY. E-mail _____

PATIENT'S FULL NAME _____
first middle last

ADDRESS _____
street city state **zipcode**

HOME PHONE ( ) _____ WORK PHONE ( ) _____

SOCIAL SECURITY NUMBER ____/____/____ SEX: M F MARITAL STATUS ____ **BIRTHDATE** ____/____/____

EMPLOYED BY _____ OCCUPATION _____ DENTAL INSURANCE? Y N

WORK ADDRESS _____
street city state **zipcode**

SPOUSE'S FULL NAME _____
first middle last

SPOUSE'S SOCIAL SECURITY NUMBER ____/____/____ **BIRTHDATE** ____/____/____

SPOUSE EMPLOYED BY _____ WORK PHONE ( ) _____

SPOUSE'S WORK ADDRESS _____
street city state **zipcode**

RESPONSIBLE PARTY (if patient is a minor) _____

ADDRESS (if different from above) _____
street city state **zipcode**

NAME OF NEAREST LIVING RELATIVE NOT LIVING WITH YOU _____

RELATIONSHIP TO PATIENT _____ PHONE NUMBER ( ) _____

ADDRESS OF NEAREST RELATIVE _____
street city state **zipcode**

YOUR INSURANCE CARRIER _____ PHONE NUMBER ( ) _____

ADDRESS FOR CLAIM SUBMISSION _____
street/p.o. box city state **zipcode**

GROUP NUMBER _____ POLICY NUMBER _____

ARE YOU INSURED THROUGH YOUR EMPLOYER OR YOUR SPOUSE'S EMPLOYER? (circle one)

DO YOU HAVE DUAL COVERAGE? Y N SECONDARY CARRIER _____

CONSENT (IMPORTANT: PLEASE READ CAREFULLY AND SIGN BELOW):

The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor in order to make a thorough diagnosis of the patient's dental needs. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with me. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment. **I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time the services are rendered unless other arrangements have been made. I understand that insurance is filed in this office as a courtesy to me, and I am responsible for all unpaid balances. Payment may be made at time of service in cash, by check, or by credit cards (Visa, Mastercard, American Express, Discover).** I understand that, when appropriate, credit bureau reports may be obtained. I also understand it is my responsibility to advise this office of any changes in the information contained on this form. A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours. This fee only covers a portion of the overhead such as salaries, electric, rent, etc., which still must be paid.

Patient or Guardian Signature _____ **Date** ____/____/____

OVER PLEASE

MEDICAL AND DENTAL INFORMATION

HAVE YOU EVER HAD A REACTION TO OR ARE ALLERGIC TO ANY MEDICATION? Y N

IF SO, PLEASE SPECIFY _____

CHIEF ORAL COMPLAINT _____

NAME OF PREVIOUS DENTIST _____ LAST VISIT DATE _____
month, year

WERE X-RAYS TAKEN AT YOUR PREVIOUS DENTAL OFFICE? Y N HOW LONG AGO? _____

DO YOU HAVE/USE ANY OF THE FOLLOWING (indicate with a check mark in the space provided):

_____ Teeth sensitive to cold, sweets, pressure
_____ Bleeding gums (indicate how long) _____
_____ Food impaction/catching in teeth/gums
_____ Clenching or grinding
_____ Burning of tongue
_____ Swelling or lumps in mouth
_____ Frequent blisters on lips or in mouth
_____ Pain around ear
_____ Unusual sounds in ear while eating
_____ Cigarettes, cigar or pipe smoking
_____ Pain or difficulties opening mouth
_____ Dental floss
_____ Water pik or other water jet devices
_____ Fluoride supplements

_____ Bad breath
_____ Unpleasant taste
_____ Unfavorable dental experience
_____ Periodontal treatment
_____ Orthodontic treatment/braces
_____ Mouth breathing
_____ Oral habits (fingernail/cheek biting)
_____ Any missing teeth not replaced?
_____ If so, how many
_____ Texture of toothbrush (soft/med/firm)
_____ Frequency of brushing (per day)
_____ Interdental stimulators
_____ Disclosing tablets or solutions
_____ Cosmetic concerns

PHYSICIAN'S NAME _____ DATE OF LAST EXAM _____
month, year

PHONE NUMBER ( ) _____ ADDRESS _____
street city state zipcode

ARE YOU CURRENTLY HAVING PAIN OR DISCOMFORT? Y N SPECIFY: _____

WERE YOU HOSPITALIZED DURING THE PAST TWO YEARS? Y N SPECIFY: _____

ARE YOU TAKING ANY MEDICATION CURRENTLY? Y N SPECIFY: _____

ARE YOU TAKING ANY BISPHOSPHONATES SUCH AS: ACTONEL, BONIVA, DIDRONEL, FOSAMAX, FOSAMAX PLUS D, SKELID, AREDIA, BONEFOS, OR ZOMETA? Y N

DO YOU FEEL PAIN/EXERTION UPON CLIMBING STAIRS? Y N WHILE TAKING A WALK? Y N

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING (indicate with a check mark):

_____ Allergies to drugs
_____ Allergies to anesthetics
_____ Heart attack/failure
_____ Angina pectoris
_____ Blood transfusion
_____ Heart surgery
_____ Pacemaker
_____ Heart murmur
_____ Mitral valve prolapse
_____ H.I.V.
_____ High blood pressure
_____ Stroke
_____ Tonsilitis
_____ Allergy to latex
_____ Cortisone medication
_____ Cancer
_____ Chemotherapy
_____ Fainting/dizzy spells

_____ Prosthetic valve/joint
_____ Neurological problems
_____ Radiation treatment
_____ Congenital heart disease
_____ Venereal disease
_____ Excessive bleeding from cut or previous extraction
_____ Anemia/blood problems
_____ Arthritis
_____ Asthma/breathing problems
_____ Hayfever or allergies
_____ Thyroid problems
_____ Tuberculosis
_____ Hemophilia
_____ Arteriosclerosis
_____ Emphysema
_____ Sicke cell disease
_____ Nervousness

_____ Diabetes
_____ Kidney problems
_____ Liver problems
_____ Drug addiction
_____ Epilepsy/seizures
_____ Hepatitis
_____ Bruise easily
_____ Psychiatric care/ emotional problems
_____ Rheumatic fever
_____ Sinus problems
_____ Eye disorders
_____ Ulcer/colitis
_____ Yellow jaundice
_____ Rheumatism
_____ Chronic cough
_____ Tumors/ Malignancies

If female, are you pregnant? Y N If yes, what month?_____ Are you nursing? Y N Are you taking birth control pills? Y N