PATIENT INFORMATION FORM

Name:_____ Nickname: _____

Address: _____
Street City / State Zip Code

Employer_____ Occupation _____

Home Ph.#_____ Work Ph.#_____ Fax.#_____

Cell Ph.#_____Pager #_____

SS#_____ Birthdate_____ Drivers Lic: _____

Spouse's Name_____ Employed by:_____

Whom may we thank for referring you to our office?_____

PERSON RESPONSIBLE FOR PAYMENT

Name_____ Relationship to patient _____

Address: _____
Street City / State Zip Code

Employer_____ Occupation _____

Home Ph.#_____ Work Ph.#_____ Fax.#_____

SS#_____ Birthdate_____

DENTAL INSURANCE INFORMATION

Primary Insurance Company_____Group # _____

Insured's Name_____SS#_____ DOB _____

DENTAL HISTORY

Do you have a dental complaint at this time? _____

What was the date of your last dental treatment? _____

How often did you see your dentist? _____

Have you ever had an unpleasant dental experience? _____

Who was your last dentist and where? _____

Do you grind or clench your teeth? Yes No

Do you have pain in your jaw joint? Yes No

Do you have sore or sensitive teeth? Yes No

Do your gums bleed? Yes No

Do you get cold or canker sores? Yes No

Do you have an unpleasant taste in your mouth? Yes No

Do you have frequent headaches? Yes No

Do you have ear aches? Yes No

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do you have any: Loose____ Cracked____ Broken teeth____? Check all that apply

Have you had periodontal treatment? _____

Have you ever worn braces? _____ When? _____Dr's name: _____

Do you have any missing teeth? _____Have they been replaced? _____

If so how? Fixed bridge____ Removable partial____ Denture____ Implant ____

How do you feel about the appearance of your smile? _____

Would you be interested in whiter teeth? _____ , or cosmetic dentistry to improve your smile? ____

Name of spouse or parents _____

Work place of spouse _____phone number _____

Whom should we contact in case of an emergency? _____

Who may we thank for referring you to our office? _____

MEDICAL HISTORY

PATIENT NAME_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? O Yes O No O N/A _____

Have you ever been hospitallized or had a major operation? O Yes O No O N/A _____

Have you ever had a serious head or neck injury? O Yes O No O N/A _____

Are you taking any medications, pills, or drugs? O Yes O No O N/A _____

Do you take, or have you taken, Phen-Fen or Redux ? O Yes O No O N/A Do you use tobacco? O Yes O No O N/A

Are you on a special diet? O Yes O No O N/A Do you use controlled substances? O Yes O No O N/A

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptive?

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other_____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? O Yes O No O N/A _____

Comments: _____

_____

_____

*Condition may require medication N/A - Not answered by patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE