PATIENT INFORMATION

Patient Name: _____ Patient #: _____ Date: _____
Last First M

Address: _____
Street Apt# City State Zip

Birthdate: ____/____/____ Telephone: Home: _____ Work: _____ Cell: _____
Email: _____
Height: _____ Weight: _____ Sex: ☐ M ☐ F Check One: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated
If Student, _____ ☐ Full Time ☐ Part Time
Name of School/College City State Grade
Patient's Employer: _____ Occupation: _____ SS#: _____
Business Address: _____
Street Suite# City State Zip
Spouse Name: _____ Employer: _____Work Phone: _____
Person to contact in case of emergency: _____ Relationship: _____Phone: _____
If you are completing this form for another person, what is your relationship to that person? _____
Whom may we thank for referring you to our office? _____
Name of Person Responsible for this Account: _____ Relationship to Patient: _____
Address (if different from above): _____
Street Apt# City State Zip
Birthdate: _____/_____/_____ Telephone: Home: _____ Cell: _____
SS # _____ Driver's License # _____

PRIMARY DENTAL COVERAGE INFORMATION If you do NOT have primary coverage, please check this box: ☐
Name of Insured: _____ Relationship to Patient: _____ Birthdate: ____/____/____
Address (if different from above): _____ City: _____State: _____ Zip: _____
SS #: _____Driver's License # _____ Date Employed: _____
Name of Employer: _____ Union or Local # _____ Telephone: Work: _____ Home: _____
Address of Employer: _____ City: _____ State: _____ Zip: _____
Dental Ins. Company: _____ Group #: _____ Policy ID #: _____

SECONDARY DENTAL COVERAGE INFORMATION If you do NOT have primary coverage, please check this box: ☐
Name of Insured: _____ Relationship to Patient: _____ Birthdate: ____/____/____
Address (if different from above): _____ City: _____State: _____ Zip: _____
SS #: _____Driver's License # _____ Date Employed: _____
Name of Employer: _____ Union or Local # _____ Telephone: Work: _____ Home: _____
Address of Employer: _____ City: _____ State: _____ Zip: _____
Dental Ins. Company: _____ Group #: _____ Policy ID #: _____

DENTAL HISTORY

Please answer each question by circling Yes or No

Do you have a specific dental problem or chief complaint? Describe: _____ Yes No
Do you have dental examination on a routine basis? When was your last visit? _____ Yes No
Do you think you have cavities or gum disease? _____ Yes No
Do you brush or floss on a routine basis? Describe: _____ Yes No
Do your gums ever bleed? Describe: _____ _____ Yes No
Do you like your smile? Why? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office been positive? _____ Yes No
Name of previous dentist: _____ Date of last full mouth x-ray series: _____
I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.
Date: _____ Signature: _____
(if patient is a minor, include printed name and signature of parent or legal guardian)

DO NOT WRITE IN THIS SPACE

DATE: _____ **REVIEWED BY:** _____ **DENTIST'S COMMENTS:** _____

HEALTH HISTORY

Patient Name: _____ Patient #: _____ Date: _____
Last First M

Please answer each question by checking the appropriate box or circling Yes or No.

1. Are you in good health? ..... Yes No
2. Date of last physical examination: _____
3. Are you now under the care of a physician? ..... Yes No
   If yes, what is the condition being treated? _____
   Doctor's name: _____ Telephone #: _____
4. Have you ever had any serious illness or operation or been hospitalized? ..... Yes No
   Please explain: _____
5. Are you taking any medication? ..... Yes No
   If yes, what? _____
6. Are you using any recreational drugs (e.g., marijuana, cocaine) or controlled substances? ..... Yes No
   If yes, what? _____
7. Have you ever been premedicated with antibiotics for your dental treatment? ..... Yes No
8. Are you sensitive or allergic to any drugs or materials? ☐ Penicillin ☐ Tetracycline ☐ Erythromycin ☐ Aspirin
   ☐ Codeine ☐ Latex ☐ Other If Other, please list: _____
9. Do you have, or have you had any of the following: Please check "Y" for Yes or "N" for No ---Answer all conditions:

☐ Y ☐ N AIDS	☐ Y ☐ N Congenital Heart Lesions	☐ Y ☐ N Hemophilia	☐ Y ☐ N Respiratory Disease
☐ Y ☐ N Allergies or Hive	☐ Y ☐ N Diabetes	☐ Y ☐ N Hepatitis or Jaundice	☐ Y ☐ N Rheumatic Fever
☐ Y ☐ N Allergies to Metal	☐ Y ☐ N Difficulty in Swallowing	☐ Y ☐ N Herpes	☐ Y ☐ N Rheumatism
☐ Y ☐ N Anemia	☐ Y ☐ N Drug Addiction	☐ Y ☐ N High Blood Pressure	☐ Y ☐ N Sickle Cell Disease
☐ Y ☐ N Angina Pectoris	☐ Y ☐ N Emphysema	☐ Y ☐ N HIV Positive	☐ Y ☐ N Sinus Trouble
☐ Y ☐ N Arthritis	☐ Y ☐ N Epilepsy or Seizures	☐ Y ☐ N Joint Replacement	☐ Y ☐ N Stomach Ulcers
☐ Y ☐ N Glaucoma	☐ Y ☐ N Excessive Bleeding	☐ Y ☐ N Kidney Disease	☐ Y ☐ N Stroke
☐ Y ☐ N Asthma	☐ Y ☐ N Fainting Spells or Seizures	☐ Y ☐ N Liver Disease	☐ Y ☐ N TMJ
☐ Y ☐ N Blood Disease	☐ Y ☐ N Hay Fever	☐ Y ☐ N Mental Disorder	☐ Y ☐ N Thyroid Disease
☐ Y ☐ N Blood Transfusion	☐ Y ☐ N Head Injuries	☐ Y ☐ N Mitral Valve Prolapse	☐ Y ☐ N Tonsillitis
☐ Y ☐ N Bruise Easily	☐ Y ☐ N Heart Ailments or Attack	☐ Y ☐ N Nervous Disorders	☐ Y ☐ N Tuberculosis
☐ Y ☐ N Chemotherapy	☐ Y ☐ N Heart Failure	☐ Y ☐ N Pain in Jaw Joints	☐ Y ☐ N Tumors or Growths
☐ Y ☐ N Cold Sores	☐ Y ☐ N Heart Murmur	☐ Y ☐ N Psychiatric Treatment	☐ Y ☐ N Venereal Disease
☐ Y ☐ N Cortisone Medicine	☐ Y ☐ N Artificial Heart Valve	☐ Y ☐ N Radiation Treatment	

10. Do you wear a cardiac pacemaker, or have you had heart surgery? If yes, please explain: _____ Yes No
11. Do you smoke, chew, use snuff or any other forms of tobacco? ☐ Cigarettes ☐ Cigars ☐ Chew ☐ Snuff ☐ Other ..... Yes No
    If yes, how much? _____
12. Do you consume alcoholic beverages? If yes, how much? _____ ..... Yes No
13. Have you ever taken the drug "Fen-Phen" or "Redux"? ..... Yes No
14. Are you Pregnant? If yes, how many months? .....N/A Yes No
15. Do you have any problem assicated with your menstrual period? .....N/A Yes No
16. Do you take birth control pills? .....N/A Yes No
17. Are you taking Fosamax or biophoshonate medications? ..... Yes No
18. Is there anything we should know about your health that is not mentioned above? ..... Yes No
    Please explain: _____

1ST I CERTIFY THAT THE ABOIVE INFORMATION IS COMPLETE AND ACCURATE:

Date: _____ Signature: _____
(If patient is a minor, include printed name and signature of parent or legal guardian)

2nd UPDATE- Since you last visit:

1. Have you seen a medcial doctor? ..... Yes No
2. Have you had a change in any medication? ..... Yes No
3. Have you had a change in any medical conditon or had surgery? Yes No

If yes, please explain: _____
Date: _____ Signature: _____

3rd UPDATE- Since you last visit:

1. Have you seen a medcial doctor? ..... Yes No
2. Have you had a change in any medication? ..... Yes No
3. Have you had a change in any medical conditon or had surgery? Yes No

If yes, please explain: _____
Date: _____ Signature: _____

Patient Responsible for Fees &Assignment of Insurance Benefits: I undersant that responsibilty for payment for Dental Services provided inthis office for myself or my dependent is mine. Unless prior special arrangement are made, accounts are to be paid on the date which services are provided. I hearby authorize that the payments from any insurance company due to me be paid directly to this office. In the even of default in my payment, patient or party responsible for fees agrees to pay any and all cost of suit, collection an dattorney's fees.

Patient or Guardian Signature: _____ Date: _____