# PATIENT INFORMATION

**PATIENT'S NAME** LAST______________________FIRST_________________MIDDLE ______SEX. M. F. BIRTHDATE_______________AGE_____

SOC. SEC. #_______________________IF PATIENT IS MINOR, GIVE PATIET'S OR GAURDIAN'S NAME____________________________DATE________

WHO MAY ME THANK FOR REFFEREING YOU TO OUR OFFICE__________________________________REASON FOR THIS VISIT_________________

## RESPOSIBLE PARTY INFORMATION

**NAME** LAST_____________________________FIRST_________________________MIDDLE_______________MARITAL STATUS______

**RESIDENCE** STREET_____________________________Apt. #_____CITY _________________________STATE____ZIP_____ ___

**MAILING ADDRESS** STREET_____________________________Apt. #_______CITY_________________________STATE______ZIP_______

**HOW LONG AT THIS ADDRESS**____________________________**HOME PHONE**_______________________________________
**CELL**___________________________

**WORK PHONE**___________________________________**EMAIL**_______________________________________________________

**PREVIOUS ADDRESS (IF LESS THAN THREE YEARS)**
**STREET**________________________________________**Apt. #** ____**CITY**________________________**STATE**______**ZIP**_______

**SOC. SEC.#**_________________________**BIRTHDAT**________**DRIVER'S LICENSE #**___________________________________

**RELATION TO PATIENT**_______________

**EMPLOYER**____________________________________**OCCUPATION**_____________**NO. YEARS EMPLOYED**_____________

## RESPOSIBLE PARTY'S SPOUSE

**NAME**..................................................................................
Last First Middle

**EMPLOYER**_____________**OCCUPATION**__________________

**SOC. SEC. #**_____________**BIRTHDATE**____________________

**HOME PH.**__________________________________________

**CELL**_____________________________________________

**WORK PH.**_________________**EMAIL**____________________

## EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU

**NAME**_____________________________________________

**RELATIONSHIP**____________________________________

**ADDRESS**_________________________________________

**CITY, STATE**______________________________________

**HOME PH:**________________________________________

**CELL**____________________________________________

**WORK PHONE:**_____________________________________

## DENTAL INSURANCE INFORMATION (PRIMARY CARRIER)

**INSURED'S NAME**____________________________________

**INSURANCE COMPNY**_________________________________

**INSURANCE CO. ADDRESS**____________________________

**INSURED'S EMPLOYER**_______________________________

**INSURED'S SOC. SEC.#**__________________**GROUP**_______
**LOCAL**_________________

***IF YOU HAVE DOUBLE DENTAL INSURANCE COVERAGE , COMPLETE THIS FOR THE SECOUND COVERAGE***

**INSURED'S NAME**________________________________

**INSURANCE COMPANY**____________________________

**INSURANCE CO. ADDRESS**_________________________

**INSURED'S EMPLOYER**____________________________

**INSURED'S SOC. SEC.#**________**GROUP**_____**LOCAL**____

# Adult Medical History

**Yes No**

**Medical History**

1. Do you have any current health problems?............ ☐ ☐
Please list............ ☐ ☐
2. When was your last physical examination? ............ ☐ ☐
3. Are you under the care of a physician? ............ ☐ ☐
If yes, for what reason(s)________________ ☐ ☐
4. Are you presently taking any medications/drugs/pills/herbals?............ ☐ ☐
If yes, please list: ________________ ☐ ☐
Have you ever taken Fen-phen/Redux............ ☐ ☐
5. (Women) Is there a chance you are pregnant? ............ ☐ ☐
If yes, How long?________________ ☐ ☐
6. Do you take oral contraceptives? ............ ☐ ☐
7. Are you allergic/sensitive to: None.. Aspirin..Codeine..Penicillin..Local..Anesthetic.Latex ..Pine.. Nuts... Dyes ________________ ☐ ☐
Are you aware of being allergic to anyother medication or substances: If yes please list___________ ☐ ☐
________________
8. Do you smoke or chew tobacco,.....Cigarettes....., Cigars....., Pipe............ ☐ ☐
If yes, which one or both and how long? ________________ ☐ ☐
9. Do you have Diabetes? ............ ☐ ☐
If Yes, please indicate .......... Type 1 Type 2 Last HbA1c date and level________________ ☐ ☐

**Yes No**

10. Do you have, or have you ever had:

| Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|
| Heart trouble... | ☐ | ☐ | High blood presure......... | ☐ | ☐ |
| Heart murmur......... | ☐ | ☐ | | | |
| Mitral valve prolapse......... | ☐ | ☐ | Herpes......... | ☐ | ☐ |
| Headaches......... | ☐ | ☐ | Anaphylaxis......... | ☐ | ☐ |
| Heart surgery ......... | ☐ | ☐ | Heart pacemaker ......... | ☐ | ☐ |
| Congenital heart defects......... | ☐ | ☐ | | | |
| Artificial heart valve/stent/graft......... | ☐ | ☐ | Food Allergy......... | ☐ | ☐ |
| Abnormal blood pressure ......... | ☐ | ☐ | Atopic (Alergy prone)......... | ☐ | ☐ |
| Stroke......... | ☐ | ☐ | Ulcers/ GERD......... | ☐ | ☐ |
| Kidney trouble/Dialysis......... | ☐ | ☐ | Tuberculosis or lung disease ......... | ☐ | ☐ |
| Asthma......... | ☐ | ☐ | Back problems......... | ☐ | ☐ |
| Sinus trouble......... | ☐ | ☐ | Epilepsy/seizures......... | ☐ | ☐ |
| Fainting spells......... | ☐ | ☐ | Tonsillitis......... | ☐ | ☐ |
| Anemia ......... | ☐ | ☐ | Leukemia......... | ☐ | ☐ |
| Excessive or prolonged bleeding ......... | ☐ | ☐ | Thyroid problem......... | ☐ | ☐ |
| Jaundice ......... | ☐ | ☐ | Hepatitis(Type)......... | ☐ | ☐ |
| Cancer......... | ☐ | ☐ | Chemotherapy/radiation......... | ☐ | ☐ |
| Arthritis......... | ☐ | ☐ | Blood disease......... | ☐ | ☐ |
| Artificial joint replacements......... | ☐ | ☐ | Cortico-Steroid treatment......... | ☐ | ☐ |
| Osteoporosis/treatment w/ Bisphosphonates ......... | ☐ | ☐ | HIV positive/AIDS ......... | ☐ | ☐ |
| Oral herpetic lesions......... | ☐ | ☐ | Sexually Transmitted disease ......... | ☐ | ☐ |
| Psychiatric care ......... | ☐ | ☐ | Glaucoma......... | ☐ | ☐ |
| Hearing impaired......... | ☐ | ☐ | Chemical dependency......... | ☐ | ☐ |
| Circulatory problems......... | ☐ | ☐ | Caugh (persistent)......... | ☐ | ☐ |

**Patient's Signature**________________________ Date________________

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Diabetes........................................................................ | ☐ | ☐ | Caugh up blood............................ | ☐ | ☐ |
| Jaw Pain.......................................................................... | ☐ | ☐ | Kidney Disease or malfunction... | ☐ | ☐ |
| **Material Allergies...Latex...wool.....metal....chemicals** | | | Rapid weight loss or gain............ | ☐ | ☐ |
| Respiratory disease......................................................... | ☐ | ☐ | Ruheumatic/scarlet fever........... | ☐ | ☐ |
| Shingles........................................................................... | ☐ | ☐ | Shortness of breath..................... | ☐ | ☐ |
| Skin Rash......................................................................... | ☐ | ☐ | Spina Bifida................................ | ☐ | ☐ |
| Surgical Implant............................................................. | ☐ | ☐ | Swelling of feet of ankles............ | ☐ | ☐ |
| Do you take pre-medication for anything................... | ☐ | ☐ | | | |

If you are pre-medicated for what______________________________________________

______________________________________________

11. Have you had any other serious illness, hospitalization or accident? ………......................................... ☐ ☐

If yes, please explain______________________________________________ ☐ ☐

**Patient's Signature**______________________________Date____________________

# Dental History

**Yes No**

1. Former Dentist Address/Name/Telephone________________________ ☐ ☐
________________________ ☐ ☐
________________________ ☐ ☐
2. When did you last visit a dentist?________________Complete date________ ☐ ☐
When was your last cleaning? ____________ X-rays taken?...... Date…........................ ☐ ☐
If yes: Full Mouth Series Bitewings Panoramic What was done at your last visit? ________ ☐ ☐
________________________
Why did you leave that dentist?________________________ ☐ ☐
Has any dental treatment been recommended to you that you have not had done? ________ ☐ ☐
________________________ ________
________________________
3. Are you aware of any dental problems?............................................. ………………….......…....... ☐ ☐
Explain:________________________ ☐ ☐
________________________
________________ ________________
4. Please rate the present condition of your mouth. Poor 1... 2 ...3... 4.. 5.. 6 ..7.. 8.. 9.. 10 Excellent
5. Have you ever been treated for gum disease? … … … …… … … … … …… … …..........….. …... ☐ ☐
If yes, what was done?________________________ ________ ☐ ☐

6. Do you have well water? …………………………………………………………...........…..….. ☐ ☐
7. Is your water fluoridated? ………………………………………………………..........……..….. ☐ ☐
8. Are your teeth sensitive to: anything Sweet, Cold, Heat or Pressure ................................................. ☐ ☐
9. Please rate the appearance of your smile. Poor 1 ..2.. 3.. 4 ..5.. 6.. 7.. 8.. 9 ..10 …Excellent
10. Would you like a whiter smile? ………………………………………………………..........…... . ☐ ☐
11. Would you like straighter teeth? ………………………………………………………..........……..... ☐ ☐
12. Have you had your teeth straightened/worn braces? ………………………….......………...… ☐ ☐
13. Are you concerned with bad breath (malodor)? ……………………………………….........…..... ☐ ☐
14. Are you concerned with snoring or sleep apnea? ……………………………………..........… ☐ ☐
15. Are you concerned with grinding or clenching your teeth (bruxism)?……………….........…… ☐ ☐
16. Do you wear a bite guard? ………………………………………………………........................ ☐ ☐
17. Are you aware of possible TMJ problems- does your jaw joint make noise, ................................. ☐ ☐
lock up or create pain?.......................................................................................................................... ☐ ☐
18. Are you interested in sleep/ sedation dentistry? ……………………………………..........… ☐ ☐
19. Is there anything else that would be valuable for your dentist to know to best care for you? ☐ ☐
20. Are happy with the apparance of your teeth?.................................................................................. ☐ ☐
21 Headaches,.......Earaches.........Neck pain.......................................................................................... ☐ ☐
22.Do you regularly use dental floss.................................................................................................... ☐ ☐
23.Do you wear dentures or partial...................................................................................................... ☐ ☐
are you happy with dentures.............................................................................................................. ☐ ☐
24.Have you ever do periodantal gum treatment.................................................................................. ☐ ☐
25.Are you apprehensive about dental treatment................................................................................. ☐ ☐
26. Do you regularly use DENTAL FLOSS?........................................................................................ ☐ ☐

**Patient's Signature**________________________Date________________

**PLEASE RANK THE FOLLOWING IN THE ORDER IN WHICH THEY WOULD KEEP YOU FROM HAVING DENTAL TREATMENT.** *NUMBER FROM 1 TO 10.....10 BEEN THE HIGHEST*

Fear of pain #..............Oral treatment is not a priority #.........Cost of treatment # .........Missing work time #

Patient Name (Print) ______________________________________________Date___________________
Patient Signature_________________________________________________Date____________________
Parent of child Name ______________________________Sigture______________________Date_______

• I____________________________________authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. • I authorize the release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist. • I have accurately advised my dental care provider of my current health status and any dietary or herbal supplements, medications and/or drugs (including recreational and over the counter) that I am taking or have taken in the last week.

**Patient Signature** Date (Parent/Guardian) Recorded by__________________________________________

**Dentist Signature**____________________________________________Date_________________________