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 <u>YOUR EMPLOYER</u> OR <u>YOUR SPOUSE'S EMPLOYER</u>? (circle one)

DO YOU HAVE DUAL COVERAGE? Y N SECONDARY CARRIER _____

<u>CONSENT (IMPORTANT: PLEASE READ CAREFULLY AND SIGN BELOW)</u>:
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. 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. <u>A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours</u>. 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