Patient Information

Date_____ 20_____
Patient's Name _____
Preferred Name _____ Date of Birth _____ Male _____ Female_____
Social Security Number _____ Marital Status _____
Street Address _____
_____
Mailing Address (if different than above) _____
_____
Employer Name & Address _____
Home Phone _____ Work Phone _____ Pager _____
Name of school if patient is a full time student _____
Expected Graduation Date _____
If patient is a child, give both parent's or guardian's names _____
In case of emergency, who should be notified? _____
Name _____ Address _____ Phone _____
Name _____ Address _____ Phone _____
Whom may we thank for referring you here? _____

Medical History

Are you under a physicians care now? Why? _____ Phone # _____ Yes ___ No ___
Have you ever been hospitalized or had a major operation? Discuss _____ Yes ___ No ___
Have you ever had a serious injury to your head or neck? Discuss _____ Yes ___ No ___
Are you taking any medications, pills, or drugs? What? _____ Yes ___ No ___
Are you on a special diet? Discuss _____ Yes ___ No ___
Are you allergic to any medications or substances? Please check box below
❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex Rubber ❑ Other _____ Yes ___ No ___
WOMEN (Please Check) Pregnant/Trying to get pregnant Nursing Taking oral contraceptives Discuss_____ Yes ___ No ___
Do you have or have ever had any of the following? Please check appropriate boxes

*If yes to any of the starred conditions, please call prior to your appointment . . . premedication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	❑	❑	Bruise Easily	❑	❑	Emphysema	❑	❑	Yellow Jaundice	❑	❑	Cold Sores	❑	❑
Heart Murmur*	❑	❑	Anemia	❑	❑	Tuberculosis	❑	❑	Kidney Problems	❑	❑	Fever Blisters	❑	❑
Irregular Heart Beat	❑	❑	Excessive Bleeding	❑	❑	Cancer	❑	❑	Renal Problems	❑	❑	Herpes	❑	❑
Angina/Chest Pain	❑	❑	Sickle Cell Disease	❑	❑	X-Ray Treatments (Radiation)	❑	❑	Thyroid Disease	❑	❑	Stroke	❑	❑
Heart Attack/Failure	❑	❑	Hemophilia (Bleeding Problem)	❑	❑	Chemotherapy	❑	❑	Parathyroid Disease	❑	❑	Convulsions	❑	❑
Congenital	❑	❑	Leukemia	❑	❑	Stomach/Intestinal Disease	❑	❑	Arthritis/Gout	❑	❑	Epilepsy or Seizures	❑	❑
Mitral Valve Prolapse*	❑	❑	Use of Tobacco Products	❑	❑	Ulcers	❑	❑	Rheumatism	❑	❑	Fainting or Dizziness	❑	❑
Scarlet Fever	❑	❑	Swelling of Limbs	❑	❑	Recent Weight Loss	❑	❑	Pain in Jaw Joints	❑	❑	Glaucoma	❑	❑
Rheumatic Fever	❑	❑	Lung Disease	❑	❑	Frequent Diarrhea	❑	❑	Cortisone Medicine	❑	❑	Tumors or Growths	❑	❑
Artificial Heart Valve*	❑	❑	Breathing Problem	❑	❑	Diabetes	❑	❑	Artificial Joint*	❑	❑	Nervousness	❑	❑
Heart Pace Maker*	❑	❑	Shortness of Breath	❑	❑	Excessive Thirst	❑	❑	Venereal Disease	❑	❑	Psychiatric Care	❑	❑
Heart Surgery*	❑	❑	Frequent Cough	❑	❑	Hypoglycemia	❑	❑	AIDS	❑	❑	Alzheimer's Disease	❑	❑
High Blood Pressure	❑	❑	Hay Fever	❑	❑	Liver Disease	❑	❑	HIV Positive	❑	❑	Allergies (Medicines)	❑	❑
Low Blood Pressure	❑	❑	Sinus Trouble	❑	❑	Hepatitis A (infectious)	❑	❑	Genital Herpes	❑	❑	Allergies (Pollen/Dust)	❑	❑
Blood Disease	❑	❑	Asthma	❑	❑	Hepatitis B or C	❑	❑	Drug Addiction	❑	❑	Hives or Rash	❑	❑
Participated in Phen Fen Diet	❑	❑												

Have you ever had any other serious illness not checked above? Discuss_____ Yes ___ No ___

To the best of my knowledge all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

_____
Patient Signature (Parent or Guardian)_____Date_____
Reviewed By Doctor _____ Date _____ BP _____
History Review and Significant Findings _____
_____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	_____	NONE ❑	_____	_____	_____
_____	_____	NONE ❑	_____	_____	_____
_____	_____	NONE ❑	_____	_____	_____
_____	_____	NONE ❑	_____	_____	_____
_____	_____	NONE ❑	_____	_____	_____
_____	_____	NONE ❑	_____	_____	_____

Dental Questionnaire

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. What is the chief reason for your dental visit today? _____
2. Date of last dental visit? _____ (approximate)
3. Have you ever had any serious trouble associated with previous dentistry? ❑ Yes ❑ No
4. Does dental treatment make you nervous? ❑ No ❑ Slightly ❑ Moderately ❑ Extremely
5. Have you ever had an unpleasant dental experience? ❑ Yes ❑ No
6. Has fear ever kept you from seeking dental care? ❑ Yes ❑ No
7. How often do you brush? _____ Brush is: ❑ Soft ❑ Medium ❑ Hard
8. Have you ever been treated for periodontal disease (gum disease pyorrhea, trench mouth)? ❑ Yes ❑ No
9. Do you have a denture or partial ❑ Yes ❑ No If so, how old _____ Do you wear it? ❑ Yes ❑ No
10. Do you use the following?
    Brush ❑ Yes ❑ No Dental Floss ❑ Yes ❑ No
    Fluoride rinse ❑ Yes ❑ No Other ❑ _____
11. Do you have, or have ever had any of the following:

MOUTH		TEETH	
Bleeding, sore gums	❑ Yes ❑ No	Loose Teeth	❑ Yes ❑ No
Unpleasant taste/bad breath	❑ Yes ❑ No	Sensitive to hot	❑ Yes ❑ No
Burning tongue/lips	❑ Yes ❑ No	Sensitive to cold	❑ Yes ❑ No
Frequent blister, lips/mouth	❑ Yes ❑ No	Sensitive to sweets	❑ Yes ❑ No
Swelling/lumps in mouth	❑ Yes ❑ No	Sensitive to biting	❑ Yes ❑ No
Ortho treatments (braces)	❑ Yes ❑ No	Food impaction	❑ Yes ❑ No
Biting cheeks/lips	❑ Yes ❑ No	Clenching/grinding	❑ Yes ❑ No
Clicking/popping jaw	❑ Yes ❑ No	If so when? _____	
Difficulty opening or closing jaw	❑ Yes ❑ No	Shifting in bite	❑ Yes ❑ No
		Change in bite	❑ Yes ❑ No

12. These are the things that are important to me about my dental health: _____

_____

What do you fear most about dental care? _____

Circle One:

1. My mouth is
   a) very comfortable
   b) moderately comfortable
   c) uncomfortable
2. I
   a) will do anything to keep my natural teeth
   b) want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them
3. I
   a) have set goals for my oral health with a previous dentist
   b) want to set goals concerning my dental health
4. I
   a) have always done the best that was recommended for my dental health
   b) have not done what dentists have recommended to me
   c) rarely go, and don't care much about having any dental work completed
5. I
   a) have put dentistry for myself and family high on my priority list
   b) put dentistry for myself and my family low on my priority list
   c) Dentistry is on my list but it's hard to find time
6. I think my present state of dental health is
   a) Excellent
   b) Good
   c) Poor

What are some questions about dentistry and oral health that you have never had adequately answered?_____

_____

13. Are you pleased with the appearance of your teeth? ❑ Yes ❑ No

_____

If not, what would you change?_____

Dental Insurance Information

Insured's Name_____ Insured's SS#_____ Insured's Date of Birth_____
Relationship to Patient_____ Employer Name and Phone_____
Is Employee Active or Retired?_____ Date of Retirement_____
Employer Address_____
Insurance Company Name_____ Group Number_____
Insurance Company Address_____
Insurance Company Phone_____

Is patient covered by another dental plan?_____ If yes, complete the following: _____
Insured's Name_____ Insured's SS#_____ Insured's Date of Birth_____
Relationship to Patient_____ Employer Name and Phone_____
Is Employee Active or Retired?_____ Date of Retirement_____
Employer Address_____
Insurance Company Name_____ Group Number_____
Insurance Company Address_____
Insurance Company Phone_____

Responsible Party Information

(Please complete if responsible party is not the patient)

Person Financially Responsible for Account_____
Relationship to Patient_____ Date of Birth_____ Marital Status_____
Social Security Number_____ Male_____ Female_____
Street Address_____

Mailing Address (if different)_____

Employer Name and Address_____

Home Phone_____ Work Phone_____ Pager_____

Method of Payment

Responsible party currently has an account with this office

- ❑ Yes ❑ No
- ❑ Payment in full at each appointment (cash or personal check)
- ❑ Payment in full at each appointment (❑ VISA ❑ MC ❑ Discover)
  Card #_____ Exp. Date_____
- ❑ I wish to discuss the Dental Office's Financial Policy

Authorization & Consent

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on the page and the dental medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless prior financial arrangements have been made. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. I understand that the Dental Office reserves the right to charge interest on any account over thirty (30) days old.

X_____
❑ Adult Patient ❑ Father (Or Husband) ❑ Mother (Or Wife) ❑ Guardian

_____
Date State Driver's License #