# PATIENT INFORMATION AND HEALTH HISTORY

INITIAL EXAM

DATE _____

PATIENT'S NAME _____ DATE OF BIRTH _____

SINGLE MARRIED LONG TERM PARTNER DIVORCED SEPARATED WIDOWED

PATIENT'S ADDRESS _____ PHONE _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ PHONE _____

ADDRESS _____

EMPLOYED BY _____ BUSINESS PHONE _____

BUSINESS ADDRESS _____ PATIENT'S SS# _____

DENTAL INSURANCE PLAN (IF ANY) _____ REFERRED BY _____

PATIENT'S NAME _____

## DENTAL HISTORY

CHIEF ORAL COMPLAINT _____

DATE OF LAST DENTAL EXAM. _____ ANY PREVIOUS MAJOR DENTAL TREATMENT, ☐ YES ☐ NO WHEN _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING - INDICATE WITH A ( ✓ )

- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums. How long _____
- ☐ Food impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ☐ Unusual sounds in ear while eating
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Unfavorable dental experience
- ☐ Complications from extractions
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Oral habits, i.e., fingernail biting cheek biting, etc.
- ☐ Cigarettes, pipe or cigar smoking
- ☐ Texture of toothbrush _____
- ☐ Frequency of brushing _____
- ☐ Dental Floss
- ☐ Inter dental stimulators
- ☐ Water jet device
- ☐ Disclosing tablets or solution
- ☐ Fluoride supplements
- ☐ Alcohol

## MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM. _____ AGE ____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING - INDICATE WITH A ( ✓ )

- ☐ Allergies to drugs
- ☐ Allergies to anesthetics
- ☐ Any heart ailments
- ☐ High blood pressure
- ☐ Neurological problems
- ☐ Radiation treatments
- ☐ Excessive bleeding from cut or extraction
- ☐ Anemia or blood problems
- ☐ Arthritis
- ☐ Chronic Fatigue Syndrome
- ☐ Asthma
- ☐ Hay fever or allergies in general
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Latex sensitivity
- ☐ Liver problems or hepatitis
- ☐ Malignancies
- ☐ Psychiatric care/emotional problems
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Immune System Disorders (AIDS, HIV, ARC)
- ☐ Stroke
- ☐ Thyroid
- ☐ Eye disorders
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer or colitis
- ☐ Pregnancy If so, what month _____
- ☐ Venereal disease
- ☐ Other _____

List all medications here

Describe any current medical treatment including drugs taken, even though not listed above _____

*

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

SIGNATURE _____ DATE _____

(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)

**NEW PATIENT INFORMATION**

~ Medicaid Waiver Patient Intake Form ~

Patient Name: _____ Date of Birth: _____

Patient Disability:_____

**COMMUNICATION INFORMATION**

Patients Speech: (circle one) Verbal or Non-Verbal
If Verbal, describe ability to communicate: ( circle one ) effectively, fairly, poorly
Does patient understand simple commands? Yes or No

Does patient have any allergies? (Including medications, foods, latex)_____

Does patient require Oral or IV sedation for dental treatments? _____

**MOBILITY**

Can patient walk without assistance? Yes or No
Does patient have a wheelchair? Yes or No
Is patient able to sit comfortably in a dental chair? Yes or No

Reason for Today's visit_____ Has patient been complaining of any dental pain?____
Has patient been displaying any signs or symptoms of dental pain ( avoiding food, touching face or mouth, behavior changes, eating only on one side )? _____

**The Patient needs ( Check whichever Apply )**

_____ Routine Exam
_____ A Filling
_____ A Cleaning
_____ Unsure, but seems to be in pain
_____ A Lot of Work
_____ An Extraction
_____ Do not Know

**The Patients level of Cooperation:**

_____ Age appropriate
_____ Playful
_____ Wiggly/ Curious
_____ Aggressive
_____ Combative
_____ Short Attention Span
_____ Non - Focused
_____ Don't know

**Regarding whether you stay with the Patient or Remain in the Reception Area, please circle if you Agree or Disagree with the following:**

It is best if I stay with the Patient because the Patient needs me to be there. Agree or Disagree

It is best if I stay with the Patient because I can help the Doctor and Staff. Agree or Disagree

It is best if I wait in the Waiting Room because I can't help the situation. Agree or Disagree

It is best if I wait in the Waiting Room because the Doctor knows best how to handle the Patients behavior in the Dental environment. Agree or Disagree