Patient Information and Health History

In order to help us render the proper dental services to you, would you please answer the following questions? The information you give us is held strictly confidential and will not be released to anyone without your permission. Thank you for your cooperation.

Personal Information *(Please Print)*

Name _____ Today's Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____ Cell Phone _____

Date of Birth ___/___/___ Social Security Number _____ E-mail Address _____

Employed by _____ Position _____

Spouse's Name _____

Spouse Employer _____ Business Phone _____

Who may we thank for referring you? _____

Person or Relative not living with you we can notify in case of an emergency _____

Phone Number _____

Party responsible for payment (if other than youself):

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Insurance Information

Name of person carrying the insurance _____

Social Security Number of Insured _____ Date of Birth ____ / ____ / ____

Relationship to Insured Self _____ Spouse _____ Child _____ Other _____

Employer _____

Insurance Company _____ Group / Policy Number _____

Name of person carrying second insurance _____

Relationship to Insured Self _____ Spouse _____ Child _____ Other _____

Social Security Number of Insured _____ Date of Birth ____ / ____ / ____

Employer _____

Insurance Company _____ Group / Policy Number _____

Release and Authorization

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. I understand that my dental insurance carrier may pay less than my actual bill for services. I authorize payment of the dental benefits to be paid directly to the provider of services, and to the extent permitted by law, authorize release of any information related to submitted dental claims.

SIGNED: _____ Date _____

(Parent or Guardian, if minor)

Medical History

Physician's Name _____

Address _____ Phone _____

Last Complete Physical? _____ Do you have any current medical problems? _____

_____

_____

Yes ☐ No ☐ Have you had any serious illness or condition requiring hospitalization or surgery?

When? _____

What for? _____

Yes ☐ No ☐ Have you ever had abnormal bleeding associated with extractions or surgery?

_____

_____

Please list any prescription medications you are now taking:

Taking _____ For _____

Taking _____ For _____

Taking _____ For _____

Taking _____ For _____

Taking _____ For _____

Please list any nonprescription medications you take on a regular basis (i.e., herbal or vitamin supplements, breath mints, cough drops, antacids, etc.)

Taking _____ For _____

Taking _____ For _____

Taking _____ For _____

Taking _____ For _____

Taking _____ For _____

Are you allergic or have you reacted adversely to any of the following?

Please circle:							
	Penicillin	Yes ☐	No ☐	Local Anesthetics	Yes ☐	No ☐
	Cephalexin	Yes ☐	No ☐	Latex	Yes ☐	No ☐
	Antibiotics	Yes ☐	No ☐	Acrylic	Yes ☐	No ☐
	Pain pills	Yes ☐	No ☐	Other		

Please describe the reaction _____

Please Note: *The use of local anesthetics and some prescription medications on an individual using undisclosed substances such as cocaine, amphetamines, diet pills or anabolic steroids could trigger severe and even fatal reactions. Any substance disclosure is held in strict confidence.*

Indicate which of the following you have had, or have at present. *(Circle "Yes" or "No" to each item.)*

Heart (Surgery, Disease, Attack)	Yes	No	Allergies or Hives	Yes	No
Chest Pain	Yes	No	Sinus Trouble	Yes	No
Congenital Heart Disease	Yes	No	Radiation Therapy	Yes	No
Heart Murmur	Yes	No	Chemotherapy	Yes	No
High Blood Pressure	Yes	No	Tumors	Yes	No
Mitral Valve Prolapse	Yes	No	Hepatits A (infectious) B (serum) C	Yes	No
Artificial Heart Valve	Yes	No	A.I.D.S.	Yes	No
Heart Pacemaker	Yes	No	Cold Sores / Fever Blisters	Yes	No
Rheumatic Fever	Yes	No	Blood Transfusion	Yes	No
Arthritis/Rheumatism	Yes	No	Hemophilia	Yes	No
Swollen Ankles	Yes	No	Sickle Cell Disease	Yes	No
Stroke	Yes	No	Bruise Easily	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Liver Disease	Yes	No
Kidney Trouble	Yes	No	Neurological Disorders	Yes	No
Ulcers	Yes	No	Epilepsy or Seizures	Yes	No
Diabetes	Yes	No	Fainting or Dizzy Spells	Yes	No
Thyroid Problems	Yes	No	Nervous / Anxious	Yes	No
Glaucoma	Yes	No	Psychiatric / Psychological Care	Yes	No
Contact Lenses	Yes	No	Bulimia	Yes	No
Emphysema	Yes	No	Anorexia	Yes	No
Chronic Cough	Yes	No	Osteoporosis	Yes	No
Tuberculosis	Yes	No	Fibromyalgia	Yes	No
Asthma	Yes	No	Lupus	Yes	No
Hay Fever	Yes	No			

WOMEN

Are you pregnant? Yes ☐ No ☐ If yes, how many months? _____

Are you taking birth control medication? Yes ☐ No ☐

Do you anticipate becoming pregnant? Yes ☐ No ☐

Are you breast feeding? Yes ☐ No ☐

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health or the medications I take, I will inform the doctor or a staff member at my next visit.

SIGNED: _____ Date _____

(Parent or Guardian, if minor)

Dental History

When were you last seen by a dentist? _____ Name of Dentist _____

Was that visit for routine care or emergency treatment? _____

Were you satisfied with the treatment you received there? _____

What is your chief reason for making this appointment? _____

_____

Please circle "Yes" or "No". If Yes, please give details.

Yes ☐ No ☐ Are you currently experiencing any pain or discomfort? _____

Yes ☐ No ☐ Are your teeth sensitive to ☐ Hot ☐ Cold ☐ Sweets ☐ Pressure?

Yes ☐ No ☐ Do you experience discomfort while chewing? _____

Yes ☐ No ☐ Are you bothered by bad breath or a persistent bad taste in your mouth? _____

Yes ☐ No ☐ Do your gums bleed while brushing? _____

Yes ☐ No ☐ Have you ever been told you have gum disease? _____

Yes ☐ No ☐ Does food catch between your teeth? _____

Yes ☐ No ☐ Have you ever had periodontal treatment (gum surgery)? _____

Yes ☐ No ☐ Do you experience any popping or clicking in your jaw while chewing? _____

Yes ☐ No ☐ Are you aware of grinding or clenching your teeth? ☐ Occasionally ☐ Quite often ☐ Never

Yes ☐ No ☐ Are you unhappy with the appearance of your smile? _____

Yes ☐ No ☐ Do you feel you will eventually wear full dentures? _____

Yes ☐ No ☐ Do any members of your family including your parents wear full dentures? _____

Yes ☐ No ☐ Do you think your dental disease is active? _____

Yes ☐ No ☐ Do you have a fear of dental treatment? ☐ Mild ☐ Moderate ☐ Severe

Yes ☐ No ☐ Have you ever had orthodontic treatment (braces)? _____

Yes ☐ No ☐ Have you ever had a traumatic dental experience? Please describe _____

_____

_____

Yes ☐ No ☐ Is there anything else about your dental history you feel I should know? _____

_____

_____

I authorize dental treatment to be performed by the dentist and his delegated staff.

SIGNED: _____ Date _____

(Parent or Guardian, if minor)