PATIENT INFORMATION

CONFIDENTIAL

PATIENT # _____

(PLEASE PRINT)

DATE _____

NAME _____ BIRTHDATE _____ HOME PHONE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE / PROV. _____ ZIP / P.C. _____

E-MAIL _____ CELL PHONE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE / PROV. _____ ZIP / P.C. _____

SPOUSE OR PARENT/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE / PROV. _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS # / SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE / PROV. _____ ZIP / P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE / PROV. _____ ZIP / P.C. _____

INS. CO. PHONE NUMBER _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS # / SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE / PROV. _____ ZIP / P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE / PROV. _____ ZIP / P.C. _____

INS. CO. PHONE NUMBER _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	❑	❑
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	❑	❑
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	❑	❑
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____		
4. HAVE YOU EVER TAKEN FEN-PHEN / REDUX?	❑	❑
5. DO YOU USE TOBACCO?	❑	❑
6. ARE YOU WEARING CONTACT LENSES?	❑	❑

7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
❑	❑	LOCAL ANESTHETICS (EG. NOVOCAINE)	❑	❑	BARBITURATES	❑	❑	ASPIRIN
❑	❑	PENICILLIN						
❑	❑	OTHER ANTIBIOTICS	❑	❑	SEDATIVES	❑	❑	OTHER _____
❑	❑	SULFA DRUGS	❑	❑	IODINE			_____

	YES	NO
8. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)?	❑	❑
9. WOMEN ONLY:		
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	❑	❑
B) ARE YOU NURSING?	❑	❑
C) ARE YOU TAKING BIRTH CONTROL PILLS?	❑	❑

II. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
❑	❑	HIGH BLOOD PRESSURE	❑	❑	HEART DISEASE	❑	❑	CHEST PAINS
❑	❑	HEART ATTACK	❑	❑	CARDIAC PACEMAKER	❑	❑	EASILY WINDED
❑	❑	RHEUMATIC FEVER	❑	❑	HEART MURMUR	❑	❑	STROKE
❑	❑	SWOLLEN ANKLES	❑	❑	ANGINA	❑	❑	HAY FEVER / ALLERGIES
❑	❑	FAINTING / SEIZURES	❑	❑	FREQUENTLY TIRED	❑	❑	TUBERCULOSIS
❑	❑	ASTHMA	❑	❑	ANEMIA	❑	❑	RADIATION THERAPY
❑	❑	LOW BLOOD PRESSURE	❑	❑	EMPHYSEMA	❑	❑	GLAUCOMA
❑	❑	EPILEPSY / CONVULSIONS	❑	❑	CANCER	❑	❑	RECENT WEIGHT LOSS
❑	❑	LEUKEMIA	❑	❑	ARTHRITIS	❑	❑	LIVER DISEASE
❑	❑	DIABETES	❑	❑	JOINT REPLACEMENT	❑	❑	HEART TROUBLE
❑	❑	KIDNEY DISEASES	❑	❑	HEPATITIS / JAUNDICE	❑	❑	RESPIRATORY PROBLEMS
❑	❑	AIDS OR HIV INFECTION	❑	❑	SEXUALLY TRANSMITTED DISEASE	❑	❑	OTHER _____
❑	❑	THYROID PROBLEM	❑	❑	STOMACH TROUBLES / ULCERS			_____
			❑	❑	IMPLANT			

COMMENTS

_____

_____

_____

_____

SIGNATURE OF DENTIST DATE

PATIENT DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	❑	❑
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	❑	❑
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS / FOODS?	❑	❑
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	❑	❑
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	❑	❑
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	❑	❑
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?	❑	❑
A) CLICKING?		
B) PAIN (JOINT, EAR, SIDE OF FACE)?		
C) DIFFICULTY IN OPENING OR CLOSING?		
D) DIFFICULTY IN CHEWING?		

	YES	NO
8. DO YOU HAVE FREQUENT HEADACHES?	❑	❑
9. DO YOU CLENCH OR GRIND YOUR TEETH?	❑	❑
10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	❑	❑
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	❑	❑
12. HAVE YOU HAD ANY ORTHODONTIC WORK?	❑	❑
13. HAVE YOU EVER HAD PROLOGED BLEEDING FOLLOWING EXTRACTIONS?	❑	❑
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	❑	❑
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	❑	❑

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X _____ _____

PATIENT, PARENT OR GUARDIAN DATE