PATIENT INFORMATION

Date _____

Name _____ Nickname _____ Birthdate _____

Address _____ City _____ State _____ Zip _____ Phone _____

Social Security No. _____ Drivers License No. _____ Cell _____

Employer _____ Address _____ Phone _____

Spouse's Employer _____ Address _____ Phone _____

Person to contact in case of emergency _____ Phone _____

Referred to office by _____

INSURANCE INFORMATION

Insured person _____ Relationship to patient _____

Birthdate of insured _____ Social Security No. _____ Payor ID _____

Name of insurance company _____ Address _____ Phone _____ Policy/Group No. _____

Do you have any other dental insurance coverage? (circle one) YES NO

If yes, name of insurance company _____ Policy/Group No. _____

DENTAL HEALTH HISTORY

Date of last dental visit _____ Date of last dental X-rays _____

Previous dentist _____ City/State _____

Reason for your visit _____

Have you had any serious trouble with previous dental treatment? (circle one) YES NO

If yes, explain _____

_____

How do you feel about dental visits? _____

Have you ever been treated for periodontal disease (gum disease)? (circle one) YES NO

If yes, when? _____

Do you have or have you ever had any of the following: (circle yes or no for each one)

Bleeding/sore gums	Y	N	Unpleasant taste/bad breath	Y	N
Burning tongue/lips	Y	N	Frequent blisters on lips, mouth	Y	N
Orthodontics (braces)	Y	N	Swelling/lumps in mouth	Y	N
Biting cheeks/lips	Y	N	Clicking/popping jaw	Y	N
Loose teeth	Y	N	Difficulty closing/opening jaw	Y	N
Sensitivity to hot	Y	N	Sensitivity to sweets	Y	N
Sensitivity to cold	Y	N	Sensitivity upon biting	Y	N
Clenching/grinding	Y	N	Shifting in teeth	Y	N
Change in bite	Y	N	Food getting stuck between teeth	Y	N

How often do you brush your teeth? _____ How often do you floss? _____

Do you use a fluoride rinse? (circle one) YES NO If yes, how often? _____

Do you use a water pik? (circle one) YES NO Do you use an electric toothbrush? (circle one) YES NO

Are you dissatisfied with the appearance of your teeth? (circle one) YES NO If yes, explain _____

_____

Are there any conditions which we should be aware of regarding your dental history? (circle one) YES NO

If yes, explain _____

OVER

MEDICAL HEALTH HISTORY
(confidential)

Date _____

Please answer the following questions by circling Yes or No.

1. Are you in good health now? Yes No
2. Are you under the care of a physician? Yes No
3. Have you ever been hospitalized or had a serious illness? Yes No
4. Have you ever had excessive bleeding following an extraction or do cuts take longer to heal than previously? Yes No
5. (Women) Are you pregnant now? (due date _____) Yes No
   Are you taking birth control pills? Yes No
6. Do you smoke or chew tobacco? If yes, how much _____ Yes No
7. Do you consume alcoholic beverages regularly? (more than 2 per day) Yes No
8. Do you have or have you ever had any of the following?

Cardiovascular Disease			Frequent nosebleeds	Y	N
- Angina	Y	N	Glaucoma	Y	N
- Heart Attack Date _____	Y	N	Headaches	Y	N
- Heart Murmur	Y	N	Hepatitis	Y	N
- High Blood Pressure	Y	N	Increase in frequency of urination at night	Y	N
- Prosthetic Heart Valve	Y	N	Jaundice (yellow skin)	Y	N
- Rheumatic Fever	Y	N	Kidney disease	Y	N
- Shortness of Breath	Y	N	Loss of hearing	Y	N
Anemia	Y	N	Marked weight change	Y	N
Arthritis/rheumatism	Y	N	Numbness/tingling	Y	N
Artificial joints	Y	N	Persistent cough	Y	N
Asthma/hay fever	Y	N	Phlegm production	Y	N
Taking or using Bisphosphonates for Bone Density	Y	N	Psychiatric treatment	Y	N
Bleeding tendency	Y	N	Radiation therapy	Y	N
Bruise easily	Y	N	Ringing in ears	Y	N
Burning upon urination	Y	N	Sexually transmitted disease		
Bypass surgery or stents Date _____	Y	N	(syphillis, AIDS, gonorrhea)	Y	N
Cancer	Y	N	Sinus problems	Y	N
Change in appetite	Y	N	Skin rashes or hives	Y	N
Change in skin color	Y	N	Stroke (enter date)_____	Y	N
Congenital heart disease	Y	N	Swelling of ankles	Y	N
Convulsions/epilepsy	Y	N	Thyroid condition	Y	N
Diabetes	Y	N	Tuberculosis	Y	N
Difficulty breathing while lying down	Y	N	Tumors or growths	Y	N
Dizziness/fainting	Y	N	Ulcers	Y	N
Emphysema	Y	N	Urethral discharge	Y	N
Family history of diabetes	Y	N			

9. Are you allergic or have you experienced a reaction to the following?
   Local anesthetic (novocaine) Yes No
   Penicillin/other antibiotics Yes No
   Aspirin, codeine, or sulfa drugs Yes No
   Steroids (cortisone, prednisone, etc.) Yes No
   Any other drug or medication _____ Yes No
10. Are you taking any medication at this time? If yes, please list the name of the medication and dosage.
    _____ _____
    _____ _____
11. Is there any disease, condition or problem not listed above that you think we should know about or is there any activity your physician says you cannot do? If so, explain. _____

I certify that I have read and answered the above questions truthfully and to the best of my knowledge.

Signature _____ Date _____

Updated health status:

Date _____ Changes _____ Initials _____
Date _____ Changes _____ Initials _____
Date _____ Changes _____ Initials _____
Date _____ Changes _____ Initials _____
Date _____ Changes _____ Initials _____
Date _____ Changes _____ Initials _____