PATIENT INFORMATION

				D	ate			
Name		_ Nickname		Birth	date			
Address								
Social Security No								
Employer								
Spouse's Employer								
Person to contact in case of emergency								
Referred to office by					Phone			
Referred to office by								
INS	SURANC	E INFORMAT	ΓΙΟΝ					
Insured person			Relationship to p	patient				
Birthdate of insuredS	ocial Securi	y No		Payor ID _				
Name of insurance company	Address		Phone	Policy/	Group No			
Do you have any other dental insurance cover	age? (ci	rcle one) YES	NO					
If yes, name of insurance company			Policy/Grou	p No				
DENTAL HEALTH HISTORY								
Date of last dental visit		Date of last den	ital Y-rays					
Previous dentist		City/State	itai x-rays					
Reason for your visit		City/State						
Have you had any serious trouble with previou								
If yes, explain								
How do you feel about dental visits?								
Have you ever been treated for periodontal dis								
If yes, when?			, ,					
Do you have or have you ever had any of the f	following: (circle yes or no fo	or each one)					
Bleeding/sore gums	Y	L Upplessant t	aste/bad breath		V			
Burning tongue/lips	Y		sters on lips, mo	uth	Y Y	N		
Orthodontics (braces)	Y N			atti	Y	7 7		
Biting cheeks/lips	Y				Y	N		
Loose teeth	Y		osing/opening ja	w	Y	N		
Sensitivity to hot	Y				Y	N		
Sensitivity to cold	Y				Y	N		
Clenching/grinding	Y N		0		Y	N		
Change in bite	Y N		stuck between	teeth	Y	N		
How often do you brush your teeth?		How often	n do vou floss?					
Do you use a fluoride rinse? (circle one) YES								
		ou use an electric						
Do you use a water pik? (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 a	aware of reg	arding your den	tal history? (circ	cle one) YF	S NO			
If yes explain		, , , , , , , , , , , , , , , , , , ,		,				

MEDICAL HEALTH HISTORY (confidential)

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Please answer the following questions by circling Yes or No. Are you under the care of a physician? Are you under the care of a physician? Have you ever bean chapitalized or had a serious illness? Have you ever bean chapitalized or had a serious illness? Have you ever had excessive bleeding following an extraction or do cuts take longer to heal than previously. Women) Are you pregnant now. (due date	DI.		V	or NI-				
2. Are you under the care of particularly and the care of particular of the care of the	rieas	e answer the following questions by circling	res	OF 140.		Yes	No	
Have you under the care of a private or had a serious illness? Have you ever bean excessive leeding following an extraction or do cuts take honger to heal than prevention of yet with the provided of the p		• Are you in good health now?						
Nonger to heal than previously? Nonger to have you ever had any of the following? Frequent nosebleeds Angina Y N Glaucoma Angina Angina Y N Headaches Y N Headaches Y N Heat Murmur Y N Hepatitis High Blood Pressure High Blood Pressure Prosthetic Heart Valve Y N Jaundice (yellow skin) Prosthetic Heart Valve Prosthetic Heart Valve Prosthetic Heart Valve Y N Jaundice (yellow skin) Nonger to hearing Y N Arrifection of the weight change Y N Real and th	3	Are you under the care of a physicians	eriou	s illnes	.e?		100	
Sologer to heal than previously (4	Have you ever been hospitalized of flad a st	wing	an ext	raction or do cuts take			
Are you pregnant now! (due Gale Yes No Are you staking pith control pills? Yes No Do you smoke or chew tobacco? If yes, how much Yes No Do you smoke or chew tobacco? If yes, how much Yes No Do you consume alcoholic beverages regularly? (more than 2 per day) Yes No		longer to Letter against V						
Are you taking birth control pills? Do you consume alcoholic beverages regularly? (more than 2 per day) Poyou consume alcoholic beverages regularly? (more than 2 per day) Poyou have or have you ever had any of the following? Cardiovascular Disease Angina Angin	5.	5 (Alexandre respective)					No	
5. Do you smoke or chew tobaccor if yes, now flucting to provide than 2 per day) 7. Do you have or have you ever had any of the following? 8. Do you have or have you ever had any of the following? 8. Cardiovascular Disease 9. Angina 9. Heart Attack Date 9. Heart Attack Date 9. Heart Murmur 9. Y. N. Headaches 9. Y. N. Headaches 9. Y. N. Heath Miller of the following? 9. Heart Murmur 9. Y. N. Hepatitis 9. Heart Murmur 9. Y. N. Increase in frequency of urination at night 9. Y. N. Headaches 9. Y. N. Hepatitis 9. Heart Murmur 9. Y. N. Kidney disease 9. Y. N. Headaches 9. Y. N. Hepatitis 9. Heart Murmur 9. Y. N. Kidney disease 9. Y. N. Headaches 9. Y. N. Hepatitis 9. Hematic Fever 9. Y. N. Kidney disease 9. Y. N. Headaches 9. Y. N. Hepatitis 9.		A					No	
Cardiovascular Disease	6.	D. Do you say be or chew tobacco? If yes, how much						
Cardiovascular Disease	7.	7. Do you consume alcoholic beverages regularly? (more than 2 per day)					No	
Cardiovascular Disease - Angina - Heart Attack Date - Y N - Headaches - Y N - Headac	8.	Do you have or have you ever had any of the	e fo	llowing	3?			
- Angina					Frequent nosebleeds	Y	N	
- Heart Attack Date		- Angina	Υ	Ν		Y	N	
- Heart Murmur - High Blood Pressure - Prosthetic Heart Valve - Prosthetic Heart Valve - Remait Fever - Shortness of Breath - Remait Fever - Shortness of Breath - Remait Fever - Shortness of Breath - Y N Kidney disease - Shortness of Breath - Y N Loss of hearing - Anemia - Arthritis/rheumatism - Y N Marked weight change - Y N - Arthritis/rheumatism - Y N Pursistent cough - Y N - Arthritis/rheumatism - Y N Pursistent cough - Y N - Asthma/hay fever - Y N Pilegm production - Y N - Asthma/hay fever - Y N Pilegm production - Y N - Bleeding tendency - Y N Radiation therapy - Y N - Brusing upon urination - Y N - Burning upon urination - Y N - Sexually transmitted disease - Bypass surgery or stents Date - Y N Six rashes or hives - Change in appetite - Y N Six rashes or hives - Change in skin color - Y N Six rashes or hives - Convulsions/epilepsy - Y N Tuberculosis - Y N - Difficulty breathing while lying down - Y N Tuberculosis - Y N - Dispersed in this part of the properties o		- Heart Attack Date					N	
- High Blood Pressure		- Heart Murmur			Hepatitis			
- Prosthetic Heart Valve Y N Jaundice (yellow skin) Y N Shortness of Breath Y N Loss of hearing Y N Anemia Y N Arthritis/rheumatism Y N N Aumbness/tingling Y N Arthritis/rheumatism Y N N Numbness/tingling Y N Arthritis/rheumatism Y N N Persistent cough Y N Arthritis/rheumatism Y N P Persistent cough Y N Arthritis/rheumatism Y N P Persistent cough Y N Asthma/hay fever Y N P Helgem production Y N B Isleeding tendency Y N B Isleeding tendency Y N R Asthma/hay fever Y N P Persistent cough Y N P Persistent cough Y N B Isleeding tendency Y N R Adiation therapy Y N R Asthma/hay fever R N R Asthma/hay fever R N R Asthma/hay fever R N R N R Hay f			Υ		Increase in frequency of urination at night			
- Rheumatic Fever			Y	N	Jaundice (yellow skin)	Y		
- Shortness of Breath Y N Loss of hearing Y N Anemia Y N N Antermia Y N N Marked weight change Y N N Arthritis/neumatism Y N N Numbness/tingling Y N N Arthritis/neumatism Y N N Numbness/tingling Y N N Arthritis/neumatism Y N N Persistent cough Y N Asthma/hay fever Y N Phlegm production Phlegm producti			Υ	N	Kidney disease			
Arthritis/rheumatism Y N Numbness/tingling Y N Artificial joints Y N Persistent cough Y N Persistent cough Y N Persistent cough Y N Plating or using Bisphosphonates for Bone Density Y N Plating or using Bisphosphonates for Bone Density Y N Plating production Y N Bleeding tendency Y N Bleeding tendency Y N Radiation therapy Y N Bleeding tendency Y N Radiation therapy Y N Radiation therapy Y N Burning upon urination Y N Ringing in ears Y N Burning upon urination Y N Sexually transmitted disease (syphillis, AIDS, gonorrhea) Y N Cancer Y N Sinus problems Y N Stroke (enter date) Y N Convellations/epilepsy Y N Stroke (enter date) Y N Stroke (enter date) Y N Diabetes Y N Diabetes Y N Thyroid condition Y N Dizziness/fainting while lying down Y N Tuberculosis Y N Difficulty breathing while lying down Y N Tuberculosis Y N Dizziness/fainting W N Ulcers Y N Ulcers Y N Stroke (enter date) Y N Stroke (enter date) Y N Stroke (enter date) Y N Dizziness/fainting Y N Ulcers Y N Ulcers Y N Dizziness/fainting Y N Ulcers Y N Stroke (enter date) Y N Dizziness/fainting W N Ulcers Y N Ulcers Y N Stroke (enter date) Y N Dizziness/fainting W N Ulcers Y N Ulcers Y N Stroke (enter date) Y N Stroke (enter date) Y N Ulcers Y N N Stroke (enter date) Y N Dizziness/fainting W N Ulcers Y N Ulcers Y N N Stroke (enter date) Y N Ulcers Y N N Stroke (enter date) Y N N Stroke (enter date) Y N N Dizziness/fainting W N N Ulcers Y N N N N N N N N N N N N N N N N N N			Y	N	Loss of hearing			
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Asthma/hay fever		Arthritis/rheumatism			Numbness/tingling			
Taking or using Bisphosphonates for Bone Density Y N Bleeding tendency Y N Radiation therapy Y N Beluse easily Y N Radiation therapy Y N Radiation therapy Y N Radiation therapy Y N Radiation therapy Y N Ringing in ears Y N Burning upon urination Y N Sexually transmitted disease Burning upon urination Y N Sexually transmitted disease Sexually transmitted disease Sexually transmitted disease Y N Surphilis, AIDS, gonorrhea) Y N Sexually transmitted disease Y N Sexually transmitted disease Y N Sinus problems Y N Stroke (enter date) Y N Congenital heart disease Y N Swelling of ankles Y N Congenital heart disease Y N Swelling of ankles Y N Diabetes Y N Thyroid condition Y N Thyroid condition Y N Dizziness/fainting Y N Tuberculosis Y N Dizziness/fainting Y N Tuberculosis Y N Dizziness/fainting Y N Ulcers Y N Tuberculosis Y N N N Tuberculosis Y N N N N N N Tuberculosis Y N N N N N N N N N N N N N N N N N N								
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Bypass surgery or stents Date					Ringing in ears	Y	N	
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Diabetes					Thursid condition			
Difficulty breathing while lying down Y N Tumors or growths Dizziness/fainting Y N Ulcers Y N Emphysema Y N Ulcers Y N Emphysema Y N Ulcers Y N Ulcers Y N S Emphysema Y N Urethral discharge Y N S Emphysema Y N Urethral discharge Y N S Emphysema Y N S Emphysema Y N S Ulcers Y N S S Are you allergic or have you experienced a reaction to the following? 1. Local anesthetic (novocaine) Yes No S Steroids (cortisone, prednisone, etc.) Yes No S S Aspirin, codeine, or sulfa drugs Yes No S S Any other drug or medication Yes No S S Any other drug or medication S Yes No S S Are you taking any medication at this time? If yes, please list the name of the medication and dosage. 1. 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. 1. 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. 1. 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. 1. 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. 1. 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. 1. 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. 1. 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. 1. Is there any disease, condition or problem not listed above that you think we should know about or is there any activity your physician s								
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Any other drug or medication								
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10. Are you taking any medication at this time? If yes, please list the name of the medication and dosage. ———————————————————————————————————		Any other drug or medication				Yes	No	
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