

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 _____					

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

- | | | |
|---------------------------|---|---|
| - Angina | Y | N |
| - Heart Attack Date _____ | Y | N |
| - Heart Murmur | Y | N |
| - High Blood Pressure | Y | N |
| - Prosthetic Heart Valve | Y | N |
| - Rheumatic Fever | Y | N |
| - Shortness of Breath | Y | N |

Anemia

Arthritis/rheumatism Y N

Artificial joints Y N

Asthma/hay fever Y N

Taking or using Bisphosphonates for Bone Density Y N

Bleeding tendency Y N

Bruise easily Y N

Burning upon urination Y N

Bypass surgery or stents Date _____ Y N

Cancer Y N

Change in appetite Y N

Change in skin color Y N

Congenital heart disease Y N

Convulsions/epilepsy Y N

Diabetes Y N

Difficulty breathing while lying down Y N

Dizziness/fainting Y N

Emphysema Y N

Family history of diabetes Y N

Frequent nosebleeds

Glaucoma Y N

Headaches Y N

Hepatitis Y N

Increase in frequency of urination at night Y N

Jaundice (yellow skin) Y N

Kidney disease Y N

Loss of hearing Y N

Marked weight change Y N

Numbness/tingling Y N

Persistent cough Y N

Phlegm production Y N

Psychiatric treatment Y N

Radiation therapy Y N

Ringing in ears Y N

Sexually transmitted disease (syphilis, AIDS, gonorrhea) Y N

Sinus problems Y N

Skin rashes or hives Y N

Stroke (enter date) _____ Y N

Swelling of ankles Y N

Thyroid condition Y N

Tuberculosis Y N

Tumors or growths Y N

Ulcers Y N

Urethral discharge 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 _____