

PATIENT INFORMATION

DATE _____

SS / HIC / PATIENT ID # _____

PATIENT _____

ADDRESS _____

CITY _____

STATE _____ ZIP _____

EMAIL _____

SEX M F AGE _____

BIRTH DATE _____

MARRIED WIDOWED SINGLE MINOR
 SEPARATED DIVORCED PARTNERED FOR _____ YEARS

OCCUPATION _____

PATIENT EMPLOYER / SCHOOL _____

EMPLOYER / SCHOOL ADDRESS _____

EMPLOYER / SCHOOL PHONE (_____) _____

SPOUSE'S NAME _____

BIRTH DATE _____

SS# _____

SPOUSES'S EMPLOYER _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

DENTAL INSURANCE

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

RELATIONSHIP TO PATIENT _____

INSURANCE CO. _____

GROUP # _____

IS PATIENT COVERED BY ADDITIONAL INSURANCE? YES NO

SUBSCRIBER'S NAME _____

BIRTH DATE _____

RELATIONSHIP TO PATIENT _____

INSURANCE CO. _____

GROUP # _____

ASSIGNMENT AND RELEASE
 I certify that I, and / or my dependent(s), have insurance coverage with _____
 _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submission.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please Print Name of Patient, Parent, Guardian or Personal Representative

Date _____
Relationship to Patient

PHONE NUMBERS

HOME (_____) _____ WORK (_____) _____ EXT. _____ CELL (_____) _____

SPOUSE'S WORK (_____) _____ BEST TIME AND PLACE TO REACH YOU _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

| | |
|----------------------------|----------------------|
| NAME _____ | RELATIONSHIP _____ |
| HOME PHONE (_____) _____ | WORK (_____) _____ |

DENTAL HISTORY

| | | |
|--|--|---|
| REASON FOR TODAY'S VISIT _____ | Burning Sensation on Tongue <input type="checkbox"/> YES <input type="checkbox"/> NO | Mouth Breathing <input type="checkbox"/> YES <input type="checkbox"/> NO |
| _____ | Chew on one side of Mouth <input type="checkbox"/> YES <input type="checkbox"/> NO | Mouth Pain, brushing <input type="checkbox"/> YES <input type="checkbox"/> NO |
| FORMER DENTIST _____ | Cigarette, Pipe or Cigar Smoking <input type="checkbox"/> YES <input type="checkbox"/> NO | Orthodontic Treatment <input type="checkbox"/> YES <input type="checkbox"/> NO |
| CITY / STATE _____ | Clicking or Popping Jaw <input type="checkbox"/> YES <input type="checkbox"/> NO | Pain around Ear <input type="checkbox"/> YES <input type="checkbox"/> NO |
| DATE OF LAST DENTAL VISIT _____ | Dry Mouth <input type="checkbox"/> YES <input type="checkbox"/> NO | Periodontal Treatment <input type="checkbox"/> YES <input type="checkbox"/> NO |
| DATE OF LAST DENTAL X-RAYS _____ | Fingernail Biting <input type="checkbox"/> YES <input type="checkbox"/> NO | Sensitivity to Cold <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Place a mark on "YES" or "NO" to indicate if you have had any of the following: | Food Collection between the Teeth <input type="checkbox"/> YES <input type="checkbox"/> NO | Sensitivity to Heat <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Bad Breath <input type="checkbox"/> YES <input type="checkbox"/> NO | Foreign Objects <input type="checkbox"/> YES <input type="checkbox"/> NO | Sensitivity to Sweets <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Bleeding Gums <input type="checkbox"/> YES <input type="checkbox"/> NO | Grinding Teeth <input type="checkbox"/> YES <input type="checkbox"/> NO | Sores or Growths in your Mouth <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Blisters on Lips of Mouth <input type="checkbox"/> YES <input type="checkbox"/> NO | Gums Swollen or Tender <input type="checkbox"/> YES <input type="checkbox"/> NO | How often do you floss? _____ |
| | Jaw Pain or Tiredness <input type="checkbox"/> YES <input type="checkbox"/> NO | How often do you brush? _____ |
| | Lip or Cheek Biting <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | Loose Teeth or Broken Fillings <input type="checkbox"/> YES <input type="checkbox"/> NO | |

HEALTH HISTORY

PHYSICIAN'S NAME _____

DATE OF LAST VISIT _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). YES NO

Place a mark on "YES" or "NO" to indicate if you have had any of the following:

| | | | | | |
|---|--|-----------------------|--|---------------------------------|--|
| AIDS /HIV | <input type="checkbox"/> YES <input type="checkbox"/> NO | Epilepsy | <input type="checkbox"/> YES <input type="checkbox"/> NO | Respiratory Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Anemia | <input type="checkbox"/> YES <input type="checkbox"/> NO | Fainting or Dizziness | <input type="checkbox"/> YES <input type="checkbox"/> NO | Rheumatic Fever | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Arthritis, Rheumatism | <input type="checkbox"/> YES <input type="checkbox"/> NO | Glaucoma | <input type="checkbox"/> YES <input type="checkbox"/> NO | Scarlet Fever | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Artificial Heart Valves | <input type="checkbox"/> YES <input type="checkbox"/> NO | Headaches | <input type="checkbox"/> YES <input type="checkbox"/> NO | Shortness of Breath | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Artificial Joints | <input type="checkbox"/> YES <input type="checkbox"/> NO | Heart Murmur | <input type="checkbox"/> YES <input type="checkbox"/> NO | Sinus Trouble | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Asthma | <input type="checkbox"/> YES <input type="checkbox"/> NO | Heart Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO | Skin Rash | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Back Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO | Hepatitis Type _____ | <input type="checkbox"/> YES <input type="checkbox"/> NO | Special Diet | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Bleeding Abnormally, with extractions or surgery | <input type="checkbox"/> YES <input type="checkbox"/> NO | Herpes | <input type="checkbox"/> YES <input type="checkbox"/> NO | Stroke | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Blood Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO | High Blood Pressure | <input type="checkbox"/> YES <input type="checkbox"/> NO | Swollen Feet or Ankles | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cancer | <input type="checkbox"/> YES <input type="checkbox"/> NO | Jaundice | <input type="checkbox"/> YES <input type="checkbox"/> NO | Swollen Neck Glands | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Chemical Dependency | <input type="checkbox"/> YES <input type="checkbox"/> NO | Jaw Pain | <input type="checkbox"/> YES <input type="checkbox"/> NO | Thyroid Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Chemotherapy | <input type="checkbox"/> YES <input type="checkbox"/> NO | Kidney Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO | Tonsillitis | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Circulatory Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO | Liver Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO | Tuberculosis | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Congenital Heart Lesions | <input type="checkbox"/> YES <input type="checkbox"/> NO | Low Blood Pressure | <input type="checkbox"/> YES <input type="checkbox"/> NO | Tumor or Growth on Head or Neck | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cortisone Treatments | <input type="checkbox"/> YES <input type="checkbox"/> NO | Mitral Valve Prolapse | <input type="checkbox"/> YES <input type="checkbox"/> NO | Ulcer | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cough, persistent or bloody | <input type="checkbox"/> YES <input type="checkbox"/> NO | Nervous Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO | Venereal Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Diabetes | <input type="checkbox"/> YES <input type="checkbox"/> NO | Pacemaker | <input type="checkbox"/> YES <input type="checkbox"/> NO | Weight Loss, unexplained | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Emphysema | <input type="checkbox"/> YES <input type="checkbox"/> NO | Psychiatric Care | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| Do you wear contact lenses? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Radiation Treatment | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |

WOMEN:

Are you pregnant? YES NO Due Date _____ Are you nursing? YES NO
Taking birth control pills? YES NO

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

PHARMACY NAME _____

PHONE () _____

ALLERGIES

| | |
|--|---|
| <input type="checkbox"/> ASPIRIN | <input type="checkbox"/> LOCAL ANESTHETIC |
| <input type="checkbox"/> BARBITURATES (sleeping pills) | <input type="checkbox"/> PENICILLIN |
| <input type="checkbox"/> CODEINE | <input type="checkbox"/> SULFA |
| <input type="checkbox"/> IODINE | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> LATEX | _____ |

UPDATES (to be filled in at future appointments)

Has there been any change in your health since your last dental appointment? YES NO

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____

Date _____

Doctor's Signature _____

Date _____

Has there been any change in your health since your last dental appointment? YES NO

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____

Date _____

Doctor's Signature _____

Date _____