PATRICK C. PENDLETON
D.D.S. F.A.G.D.

Patient Information (Confidential)

Name _____ Date _____
First Middle Last

Address _____ City _____ State _____ Zip _____
Home phone _____ Cell# _____ Soc. Security # _____ Birth date _____
Email _____ Please confirm my appointments by: E-mail Home Phone Cell Phone (circle one)
Check Appropriate Box □ Minor □ Married □ Divorced □ Widowed □ Separated □ Single

If college student, F.T./P.T., name of school _____ City _____ State _____
Patient's or Parent's employer _____ Work phone _____
Business address _____ City _____ State _____ Zip _____
Spouse or parent's name _____ Employer _____ Work phone _____
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 _____
Driver's license # _____ Birth date _____ Soc. security # _____
Employer _____ Work phone _____
Is this person currently a patient in our office □ Yes □ No

Insurance Information

Name of insured _____ Relationship to patient _____
Birth date _____ Soc. security # _____ Date employed _____
Name of employer _____ Union or local # _____ Work phone _____
Employer address _____ City _____ State _____ Zip _____
Insurance co. _____ Tel. # _____ Grp. # _____ Policy/I.D. # _____
Ins. Co. address _____ City _____ State _____ Zip _____
Do you have any additional <u>dental</u> insurance □ Yes □ No If yes, complete the following:

Name of insured _____ Relationship to patient _____
Birth date _____ Soc. security # _____ Date employed _____
Name of employer _____ Union or local # _____ Work phone _____
Employer address _____ City _____ State _____ Zip _____
Insurance co. _____ Tel. # _____ Grp. # _____ Policy/I.D. # _____
Ins. Co. address _____ City _____ State _____ Zip _____

× _____ _____
Signature of patient or parent of minor Patient account number

Patient Medical History

Patient's name_____ Date of birth_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry that you may be receiving. Thank you for answering the following questions.

	Yes	No		Yes	No
Have there been any changes in your general health within the past year?_____	☐	☐	Have you had any abnormal bleeding?_____	☐	☐
			Do you bruise easily?_____	☐	☐
Are you under the care of a physician?_____	☐	☐	Are you wearing contact lenses?_____	☐	☐
Physician's name_____			Do you use tobacco?_____	☐	☐
Date of last physical exam_____			Have you ever taken Fen-Phen or Redux?_____	☐	☐
Have you been hospitalized for any surgical operation or serious illness? _____	☐	☐	Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?_____	☐	☐
Are you taking any medicine(s), including non-prescription medicine? _____ _____ _____	☐	☐	Do you or have you used any controlled substances?_____	☐	☐
			Do you have any disease, condition, or problem not listed above that you think I should know about?_____	☐	☐

Are you allergic to or have had reactions to:

- ☐ Local anesthetics
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Latex/rubber
- ☐ Penicillin or other antibiotics
- ☐ Aspirin
- ☐ Any metals (e.g., nickel, mercury, etc.)
- ☐ Sulfa drugs
- ☐ Iodine
- ☐ Other (please list)_____

Do you, or have you ever had, any of the following:

	Yes	No		Yes	No		Yes	No
AIDS/HIV infection	☐	☐	Fainting or dizzy spells	☐	☐	Pacemaker	☐	☐
Allergies	☐	☐	Glaucoma	☐	☐	Persistent cough	☐	☐
Anemia	☐	☐	Heart attack or angina	☐	☐	Radiation treatment	☐	☐
Arthritis or rheumatism	☐	☐	Heart defect or heart murmur	☐	☐	Rheumatic Fever/Heart Disease	☐	☐
Asthma or hay fever	☐	☐	Heart surgery	☐	☐	Scarlet fever	☐	☐
Back problems	☐	☐	Hepatitis, jaundice, liver disease	☐	☐	Sexually transmitted disease	☐	☐
Chemical dependency	☐	☐	High/low blood pressure	☐	☐	Shortness of breath	☐	☐
Chemotherapy (cancer, leukemia)	☐	☐	Hives or skin rash	☐	☐	Sinus trouble	☐	☐
Chest pain	☐	☐	Hypoglycemia	☐	☐	Stomach ulcer	☐	☐
Cold sores/fever blisters	☐	☐	Joint replacement or implant	☐	☐	Stroke	☐	☐
Congenital heart problems	☐	☐	Kidney trouble	☐	☐	Swelling of feet, ankles, hands	☐	☐
Cortisone treatment	☐	☐	Lung or breathing problems	☐	☐	Thyroid problem	☐	☐
Diabetes	☐	☐	Mental health care	☐	☐	Tonsillitis	☐	☐
Eating disorder	☐	☐	Mitral valve prolapse	☐	☐	Tuberculosis	☐	☐
Epilepsy or seizures	☐	☐	Nervousness	☐	☐	Tumors	☐	☐

Women Only:

- ☐ Are you pregnant or think you may be pregnant?
- ☐ Are you nursing?
- ☐ Are you taking birth control pills?

Patient Medical History

Reason for this visit_____
When was your last dental visit_____ What was done then_____
How often did you visit the dentist before then_____
Previous dentist (name and location)_____
Have you had a complete series of dental exams (x-rays) taken? When and where_____
How often do you brush your teeth_____ How often do you floss your teeth_____
Is your drinking water fluorinated_____

	YES	NO
Do your gums bleed while brushing or flossing_____	□	□
Are your teeth sensitive to hot or cold liquids/foods___	□	□
Are your teeth sensitive to sweet or sour liquids/foods	□	□
Do you feel pain to any of your teeth_____	□	□
Do you have any sores or lumps in or near your mouth___	□	□
Have you had any head, neck or jaw injuries_____	□	□
Have you ever experienced any of the following problems in your jaw?		
Clicking_____	□	□
Pain (joint, ear, side of face)_____	□	□
Difficulty in opening or closing_____	□	□
Difficulty in chewing_____	□	□
Do you have frequent headaches_____	□	□
Do you clench or grind your teeth_____	□	□
Do you bite your lips or cheeks frequently_____	□	□

	YES	NO
Have you noticed any loosening of your teeth_____	□	□
Does food tend to become caught between your teeth___	□	□
Have you ever had periodontal treatment (gums)_____	□	□
Ever worn a bite plate or other appliance_____	□	□
Have you ever had any difficult extractions in the past___	□	□
Have you ever had any prolonged bleeding following Extractions_____	□	□
Do you wear dentures or partials_____	□	□
If yes, date of placement_____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums_____	□	□
Have you had ortho/braces in the past_____	□	□
Would you be interested in teeth whitening_____	□	□
Have you ever had an unfavorable dental experience____	□	□

If you could change <u>anything</u> about your smile, what would you change?_____

Appointments: A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. Once an appointment is Made, please remember this time has been reserved for you.

Authorization and release

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. I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and or/health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ Date_____
Signature of patient or parent if minor

Doctor's Comments_____

_____ Signature_____ Date_____