

## 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.

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

**Are you allergic to or have had reactions to:**

- |   |   |                                      |
|---|---|--------------------------------------|
| <input type="checkbox"/> Local anesthetics                          | <input type="checkbox"/> Penicillin or other antibiotics          | <input type="checkbox"/> Sulfa drugs |
| <input type="checkbox"/> Barbiturates, sedatives, or sleeping pills | <input type="checkbox"/> Aspirin                                  | <input type="checkbox"/> Iodine      |
| <input type="checkbox"/> Latex/rubber                               | <input type="checkbox"/> Any metals (e.g., nickel, mercury, etc.) |                                      |
| <input type="checkbox"/> Other (please list) _____                  |   |                                      |

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

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

**Women Only:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Are you pregnant or think you may be pregnant? | <input type="checkbox"/> Are you nursing? | <input type="checkbox"/> Are you taking birth control pills? |
|---|---|--|



## 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 dental 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 \_\_\_\_\_

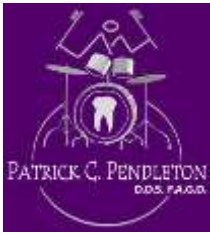
Employer address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance co. \_\_\_\_\_ Tel. # \_\_\_\_\_ Grp. # \_\_\_\_\_ Policy/I.D. # \_\_\_\_\_

Ins. Co. address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

x \_\_\_\_\_  
Signature of patient or parent of minor

\_\_\_\_\_  
Patient account number



## 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		YES	NO
Do your gums bleed while brushing or flossing _____	<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed any loosening of your teeth _____	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot or cold liquids/foods _____	<input type="checkbox"/>	<input type="checkbox"/>	Does food tend to become caught between your teeth _____	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to sweet or sour liquids/foods _____	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had periodontal treatment (gums) _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel pain to any of your teeth _____	<input type="checkbox"/>	<input type="checkbox"/>	Ever worn a bite plate or other appliance _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any sores or lumps in or near your mouth _____	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any difficult extractions in the past _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any head, neck or jaw injuries _____	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any prolonged bleeding following Extractions _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever experienced any of the following problems in your jaw? Clicking _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials _____	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face) _____	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of placement _____		
Difficulty in opening or closing _____	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever received oral hygiene instructions regarding the care of your teeth and gums _____	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing _____	<input type="checkbox"/>	<input type="checkbox"/>	Have you had ortho/braces in the past _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>	Would you be interested in teeth whitening _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your teeth _____	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an unfavorable dental experience _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you bite your lips or cheeks frequently _____	<input type="checkbox"/>	<input type="checkbox"/>			

If you could change anything 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 \_\_\_\_\_