



Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ [] Male [] Female
Address _____ City _____ State _____ Zip _____
Home Phone () _____ Cell Phone/Pager _____ SS# _____
E-Mail Address: _____
Check Appropriate Box: [] Minor [] Single [] Married [] Divorced [] Widowed [] Separated
Patient's or Parent's Employer _____ Work Phone () _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone () _____
If Patient is a Student, Name of School/College _____ City _____ State _____
How did you find out about our office? _____
Person to Contact in Case of Emergency _____ Phone () _____

RESPONSIBLE PARTY

Name of Person _____ Relationship
Responsible for this Account _____ to Patient _____
Address _____ City _____ State _____ Home Phone () _____
Social Security # _____ Birthdate _____
Employer _____ Work Phone () _____
Currently a Patient in our Office? [] yes [] no

Insurance Information

Name of Insured _____ Relationship
to Patient _____
Birthdate _____ Insurance I.D. # _____ Date Employed _____
Employer _____ Work Phone () _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Phone# _____ Group # _____ Union/Local # _____
Address _____ City _____ State _____ Zip _____
How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit? _____

Secondary Insurance Information

Name of Insured _____ Relationship
to Patient _____
Birthdate _____ Insurance I.D. # _____ Date Employed _____
Employer _____ Work Phone () _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Phone # _____ Group # _____ Union/Local # _____
Address _____ City _____ State _____ Zip _____



PATIENT INFORMATION AND HEALTH HISTORY FORM

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former Dentist _____ Date of last dental x-rays _____

Address _____

Have you had any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding your teeth | <input type="checkbox"/> Sensitivity to heat |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Sores or growths in your mouth |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Surgery to mouth or gums |

How often do you floss? _____ How often do you brush? _____

Describe any dental problem _____

Have you ever had a problem with a dental appointment? _____

How would you describe your current dental health? Good Fair Poor

What, if anything, would you change about your smile? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you had any serious illnesses, surgeries or hospitalization? Yes No If yes, describe _____

Are you under a doctor's care now? Yes No If yes, for what? _____

Have you had a change in your health in the past year Yes No If yes, describe _____

Have you ever been told you need to be premedicated or take antibiotics before dental work? Yes No If yes, for what? _____

How would you rate your current general health? Good Fair Poor

Have you taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of

Ionimin, Adipex, Fastin (phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Have you had any of the following:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sickle Cell Disease/trait |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Sinus Trouble/Hay Fever |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash/Hives |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Use/Past |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tobacco Use/Present |
| <input type="checkbox"/> Bypass | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Chewing Tobacco/Past |
| <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Chewing Tobacco/Present |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hemophilia/other
bleeding disorder | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcer |
| | | | <input type="checkbox"/> Venereal Disease |



PATIENT INFORMATION AND HEALTH HISTORY FORM

Medications

List any medication (Doctor prescribed or over the counter) you are currently taking and the correlating diagnosis:

Are you allergic to:

- Penicillin Codeine
 Aspirin Local Anesthetics

Other Allergies: _____

Is there anything that you feel is important but was not covered in this questionnaire: _____

The information presented on this form is correct to the best of my knowledge. I understand that the information contained herein will be held in strict confidence.

Signature of patient or parent if minor

Date _____

Updates (For Future Appointments)

Date	Health Change	Signature