Patient Information

Patient's Name ______________________________ Today's Date ____________________

Home Address _________________________City________________Zip______________

Email Address____________________Res. Tel.#_____________Cell #_________________

Social Security # _____-_____-_____ Date of Birth _____/_____/_____ Age________ Marital Status S/M/D/W

Your Occupation_______________ Employer________________ Bus.Tel# _____________

Spouse's Name____________________________________Social Security # _______-______-______

Your spouse's Occupation_______________ Employer_________________ Bus.Tel# __________

Insureds Name:_______________SS#______-_______-______DOB____/_____/______ID#___________

Ins. Carrier_____________Phone #____________Employer_____________Group#_________

Person to contact in an emergency_____________________Contact #__________Relation________

Party responsible for account ___________________ Bus Tel. #___________ Res Tel.#___________

What is your chief complaint or concern? ____

Whom may we thank for referring you? ____

HEALTH HISTORY

For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out all areas which pertain to you. ALL INFORMATION IS KEPT CONFIDENTIAL

Dental History:

Previous Dentist______________________ City________________ How long_____________

Date of last visit__________ Date of last dental cleaning ________ Date of last full mouth x-ray __________

1. Why did you leave your last dentist? ____
2. What did you like most about any dentist, or a dental office you have been to? ________________________
3. What did you like least about any dentist, or dental office that you have been to? ________________________
4. Are you having any discomfort at this time? ____Yes ____No
5. Have you ever had any serious trouble associated with previous dental treatment? ____Yes ____No
6. Does dental treatment make you nervous? ____Yes ____No
7. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ____Yes ____No

Check any of the following you have had or currently have:

___ Mouth Discomfort
___ Periodontal Treatment
___ Gums Bleed when Brushing
___ Awake with Sore Jaws
___ Grind or Clench your teeth
___ Pain, Clicking, Popping in Jaw Joints
___ Orthodontic Treatment
___ Immediate Relatives that have lost all of their Natural Teeth
___ Mouth Odor or Bad Taste
___ Cold Sores or Fever Blisters
___ Loose or Shifting Teeth
___ Trouble Chewing/Speaking
___ Sensitive Teeth (Hot, Cold, Sweets)
___ Snoring
___ Trouble Breathing while Sleeping
___ Complications with or following previous Dental or Oral Surgical treatment

Do you want to keep your teeth? ____ Yes, no matter how much trouble
____ Yes, if it's not too much trouble
____ I don't know
____ I don't care

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Patient Health History

Medical Health History:

1. Describe your present health ___ Excellent ___ Good ___ Fair ___ Poor
2. List your current Physician(s):.______________________________
3. Date of your last physical exam _____/_____/_____ Purpose______________________________
4. Are you aware of any changes in your general health in the last year? No Yes ____________________
5. Have you been hospitalized for illness or surgery in the past two years? No Yes ____________________
6. Have you been under a medical doctor's care during the past two years? No Yes ____________________
7. Have you ever had excessive bleeding that required special treatment? No Yes ____________________
8. Is there any history of diabetes in your family? No Yes ____________________
9. Are you on a special or restricted diet of any kind? No Yes ____________________
10. Do you smoke? ___ No ___ Yes How much?______________________ How long? ___________________
11. Do you consume drinks with caffeine? ___ No ___ Yes How many?____________________________
12. Do you consume alcoholic drinks? ___ No ___ Yes How many drinks per day ___________ per week______________
13. Are you taking blood thinners including aspirin? ___ No ___ Yes
13. Please list all medications you are now taking (include over the counter) and please explain the purpose of each.

______________________________Purpose______________________________

______________________________Purpose______________________________

List all medications you are allergic to: ______________________________

Indicate which of the following you have had or presently have, circle yes or no:

A Nervous Person	No/Yes	Epilepsy or Seizures	No/Yes	Liver Disease	No/Yes
AIDS or HIV Positive	No/Yes	Fainting or Dizzy Spells	No/Yes	Low Blood Pressure	No/Yes
Allergies or Hives	No/Yes	Frequent Headaches	No/Yes	Persistent Cough	No/Yes
Anemia	No/Yes	Frequent Thirst/Urination	No/Yes	Psychiatric Care	No/Yes
Angina	No/Yes	Glaucoma/Eye Problem	No/Yes	Radiation Treatment	No/Yes
*Arthritis Rheumatism	No/Yes	Hay Fever	No/Yes	Rheumatic Fever	No/Yes
*Artificial Joint (Knee, Hip)	No/Yes	Heart Disease or Attack	No/Yes	Scarlet Fever	No/Yes
*Artificial Heart Valve	No/Yes	Heart Murmur	No/Yes	Shortness of Breath	No/Yes
Asthma, Emphysema	No/Yes	Heart Pacemakers	No/Yes	Sinus Trouble	No/Yes
Blood Transfusions	No/Yes	Heart Surgery	No/Yes	Stroke	No/Yes
Birth control pills	No/Yes	Stomach/Intestinal Trouble	No/Yes	Taking hormone med.	No/Yes
Cancers or Tumors	No/Yes	Hemophilia	No/Yes	Thyroid Disease	No/Yes
Chemotherapy	No/Yes	Hepatitis A,B or C	No/Yes	Tuberculosis	No/Yes
Congenital Heart Lesions	No/Yes	High Blood Pressure	No/Yes	Diabetes	No/Yes
Weight Loss/Gain	No/Yes	Drug/Alcohol Addict	No/Yes	Sleep Apnea	No/Yes
If female, are you pregnant? No/Yes		Kidney or Bladder Trouble	No/Yes		

*** If yes to any of starred conditions please call prior to appointment.**

Do you have any medical conditions or diseases we should know about? No/Yes

Explain: ______________________________

To the best of my knowledge, all the preceding answers are true and correct. If I have any changes in my health or medicines, I will inform the Doctor on or before my next appointment, without fail.

Patient's Signature: ______________________________ Date: ______________________

Doctor's Signature: ______________________________ Date: ______________________

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