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PATIENT INFORMATION (Confidential)

NAME (LAST, FIRST, MIDDLE):_____

HOME ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

S.S.#:_____-_____-_____ **DOB:**_____/_____/_____

PATIENTS/PARENTS EMPLOYER:_____ **WORK PHONE:**_____

BUSINESS ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

SPOUSE/PARENTS NAME:_____

SPOUSE'S EMPLOYER:_____ **WORK PHONE:**_____

EMERGENCY CONTACT:_____ **PHONE:**_____

REFERRED BY:_____

RESPONSIBLE PARTY:

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT:_____

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

RELATIONSHIP TO PATIENT:_____ **HOME PHONE:**_____

DENTAL HISTORY

1. Date of last dental visit and/or exam: _____
2. Are you currently experiencing any dental pain? . . . . . Y / N
3. Do your gums bleed while brushing or flossing? . . . . . Y / N
4. Do you have any loose teeth or broken fillings? . . . . . Y / N
5. Are your teeth sensitive to cold, hot, sweets or biting/pressure? . . . . . Y / N
6. Do you drink soda, gatorade or energy drinks? . . . . . Y / N
   a. If yes, how often? _____
7. Have you ever been told you have periodontal disease? . . . . . Y / N
8. Have you ever had any periodontal surgery or scaling and root planing/deep cleaning? . Y / N
9. Do you have any lumps/sores in or near your mouth? . . . . . Y / N
10. Have you ever had any head, neck, or jaw injuries? . . . . . Y / N
11. Have you experienced any of the following problems with your jaw?
    - Clicking? . . . . . Y / N
    - Pain (joint, ear, or side of face)? . . . . . Y / N
    - Difficulty opening and/or closing? . . . . . Y / N
    - Difficulty eating/chewing? . . . . . Y / N
12. Do you have frequent headaches? . . . . . Y / N
13. Do you clench or grind your teeth? . . . . . Y / N
14. Do you bite your cheeks or lips? . . . . . Y / N
15. Do you snore? . . . . . Y / N
16. Have you had any difficult extractions in the past? . . . . . Y / N
17. Have you ever experienced prolonged bleeding? . . . . . Y / N
18. Have you had Orthodontic treatment (braces)? . . . . . Y / N
19. Have you been properly instructed on brushing and flossing? . . . . . Y / N

MEDICAL HISTORY

Physician: _____ Office Phone: _____

Date of Last Medical Exam: _____

1. Has there been any change in your general health within the last year? . . . . . Y / N
2. Are you under medical treatment now? . . . . . Y / N
3. Have you been hospitalized for any surgical operation or serious illness? . . . . . Y / N
4. Are you taking any medications including non-prescription medication? . . . . . Y / N
   If yes, please list medication _____
5. Do you use any form of tobacco? . . . . . Y / N
6. How often do you use alcohol? (please circle) . . . . . never . . . . . occasionally . . . . . often
7. Do you use any controlled substances? . . . . . Y / N
8. Have you ever been pre-medicated with antibiotics prior to dental treatment? . . . . . Y / N
9. Are you allergic to or have you had an allergic reaction to any of the following?
   - Local Anesthetic . . . . . Y / N
   - Penicillin/Other antibiotics . . . Y / N
   - Sulfa Drugs . . . . . Y / N
   - Barbiturates . . . . . Y / N
   - Sedatives . . . . . Y / N
   - Codeine . . . . . Y / N
   - Asprin . . . . . Y / N
   - Latex . . . . . Y / N
   - Other . . . . . Y / N
10. WOMEN ONLY:
    - A. Are you pregnant? . . . . . Y / N
    - B. Are you nursing? . . . . . Y / N
    - C. Are you currently taking birth control? . . . . . Y / N
11. Do you or have you had any of the following: (Please Circle)

High Blood Pressure	Heart Disease	Chest Pain
Low Blood Pressure	Cardiac Pacemaker	Heart Murmur
Heart Attack	Stroke	Liver Disease
Rheumatic Fever	Angina	Hepatitis/Jaundice
Hay fever/Allergies	Fainting/Seizures	Diabetes
Emphysema	Tuberculosis	AIDS/ARC
Swollen Ankles	Epilepsy/Convulsions	Stomach Trouble/Ulcers
Joint Replacement/Implant	Heart Trouble	Sexually Transmitted Diseases
Radiation Therapy	Recent Weight Loss	Respiratory Problems
Glaucoma	Easily Winded	Arthritis
Asthma	Cancer	Leukemia

OTHER: _____

AUTHORIZATION AND RELEASE:

I certify that i have read and understand the above information. To the best of my knowledge, I have answered the above questions accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the Dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such Dental care to third party insurance payers. I authorize and request my Insurance Company to pay directly to the Dentist, insurance benefits otherwise payable to me. I understand that my insurance benefits may pay less than the actual fee for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

signature of patient (or personal representative) **date**

_____ _____

signature of dentist **date**