



PATIENT HISTORY & INFORMATION

Today's Date:

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PATIENT INFORMATION

PATIENT'S NAME: Last: _____ First: _____ Middle Initial: _____ Sex: M F
 AGE: _____ BIRTH DATE: _____ Social Security #: _____

If Patient is a Minor, please provide Parents/Guardian's Name:

Who May Thank for Referring You to Our Office?

Reason for Visit Us Today?

RESPONSIBLE PARTY INFORMATION

PATIENT'S NAME: Last _____ First: _____ Middle Initial: _____ Sex: M F
 AGE: _____ BIRTH DATE: _____ Social Security #: _____ MARITAL STATUS: _____
 STREET ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____ How long have you lived here? _____
 WORK PHONE: _____ HOME PHONE: _____ CELL PHONE: _____
 EMPLOYER: _____ OCCUPATION: _____ # OF YEARS EMPLOYED: _____

RESPONSIBLE PARTY'S

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____
 EMPLOYER: _____ OCCUPATION: _____ YEARS: _____
 SS#: _____ BIRTH DATE: _____
 HOME PHONE: _____ CELL/EVENING PHONE: _____
 EMAIL: _____

EMERGENCY INFORMATION:

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____
 ADDRESS: _____
 RELATIONSHIP TO PATIENT: _____ BIRTH DATE: _____
 HOME PHONE: _____ CELL/EVENING PHONE: _____
 EMAIL: _____

PRIMARY DENTAL INSURANCE INFORMATION:

INSURED'S NAME: _____
 RELATIONSHIP TO PATIENT: _____
 INSURANCE COMPANY: _____
 RELATIONSHIP TO PATIENT: _____ BIRTH DATE: _____
 HOME PHONE: _____ CELL/EVENING PHONE: _____
 EMAIL: _____

SECONDARY DENTAL INSURANCE COVERAGE:

INSURED'S NAME: _____
 RELATIONSHIP TO PATIENT: _____
 INSURANCE COMPANY: _____
 RELATIONSHIP TO PATIENT: _____ BIRTH DATE: _____
 HOME PHONE: _____ CELL/EVENING PHONE: _____
 EMAIL: _____

It is important that we know your Medical and Dental History. This information is strictly confidential and will not be released to anyone. Please check YES or NO to the items below. Thank you.

DENTAL HISTORY	YES	NO
How Long since you last saw a dentist?	<input type="checkbox"/>	<input type="checkbox"/>
How Long since your last complete Dental Exam?	<input type="checkbox"/>	<input type="checkbox"/>
How Long since your last full-mouth X-RAYS?	<input type="checkbox"/>	<input type="checkbox"/>
Are you having PROBLEMS now?	<input type="checkbox"/>	<input type="checkbox"/>
What PROBLEMS are you experiencing?	<input type="checkbox"/>	<input type="checkbox"/>
Is Your present dental health POOR?	<input type="checkbox"/>	<input type="checkbox"/>
Do You Wear DENTURES?	<input type="checkbox"/>	<input type="checkbox"/>
Are you UNHAPPY with your dentures?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like to know more about PERMANENT REPLACEMENTS?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any Periodontal (GUM) Treatments?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums BLEED or feel IRRITATED or TENDER?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth SENSITIVE to heat, cold, sweets? (circle)	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of GRINDING or CLENCHING your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have HEADACHES, EARACHES, or NECK PAINS?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever worn BRACES (Orthodontics)	<input type="checkbox"/>	<input type="checkbox"/>
Do you have DISCOLORED teeth that bother you?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like to IMPROVE or CHANGE your smile?	<input type="checkbox"/>	<input type="checkbox"/>
Do you regularly use DENTAL FLOSS?	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HISTORY	YES	NO
Do you have any CURRENT MEDICAL PROBLEMS?	<input type="checkbox"/>	<input type="checkbox"/>
Are you under a PHYSICIAN'S CARE now?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking any MEDICATIONS?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken Fen-Phen/Redux?	<input type="checkbox"/>	<input type="checkbox"/>
Are you PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>
Do you SMOKE cigars, cigarettes or chew tobacco? (circle)	<input type="checkbox"/>	<input type="checkbox"/>

Please CHECK YES OR NO TO THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	YES	NO		YES	NO
AIDS/HIV Positive.	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease/Attack/Murmur?	<input type="checkbox"/>	<input type="checkbox"/>	Stroke, hardening of arteries?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, Emphysema, other Lung Diseases?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, other Liver Disease?	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Problems, Ulcers?	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid, Adrenal Disease?	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Treatments?	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Heart Valve?	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder?	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea or use CPAP Machine?	<input type="checkbox"/>	<input type="checkbox"/>
Tumors, Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism?	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
Kidney, Bladder Disease?	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint?	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>
Drug Abuse?	<input type="checkbox"/>	<input type="checkbox"/>	Fainting?	<input type="checkbox"/>	<input type="checkbox"/>

Name of Previous Dentist:

City: _____ State: _____

Is there any other Medical or Dental Information that you feel we should know about?

Family Physician: _____ Phone: _____ Email: _____

Patient Signature (Parent of Child) _____ Date: _____ Dentist Signature: _____