

# PATIENT INFORMATION

Date \_\_\_\_\_

Name: Dr. Mr. Mrs. Ms. \_\_\_\_\_  
Last First Middle

Child Single Married Divorced Widowed Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Business Phone \_\_\_\_\_ Ext. \_\_\_\_\_ E-Mail \_\_\_\_\_

Social Security # \_\_\_\_\_ Driver's License No. \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Dental Insurance Yes No If Yes, Insurance Name \_\_\_\_\_ Group # \_\_\_\_\_

Insured Person's Full Name \_\_\_\_\_ Date Of Birth \_\_\_\_\_

SS # \_\_\_\_\_ Relationship To Patient \_\_\_\_\_

Employer's Name \_\_\_\_\_

Has any member of your family been treated in our office? Yes No

Whom may we thank for referring you to our office? \_\_\_\_\_

Call In Case Of Emergency \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Reason For Visit \_\_\_\_\_ Best Time To Call \_\_\_\_\_ Alternate \_\_\_\_\_

## MEDICAL HEALTH

Name And Address Of Physician \_\_\_\_\_

Physician's Phone # \_\_\_\_\_ Last Complete Physical? \_\_\_\_\_

Please Check Those Conditions That Now Or Have Ever Pertained To You

Overall General Health Excellent Good Fair Poor

YES NO YES NO

Are you currently under the care of a physician?

Heart Murmur or Congenital Heart Defect

Heart Surgery or Heart Disease

Rheumatic Fever

Heart Pacemaker

Open Heart Surgery

Stroke

Abnormal Blood Pressure High/Low

Artificial Heart Valve

Dizziness or Fainting Spells

Diabetes

Kidney Disease

Jaundice or Liver Disease

Cancer

Hepatitis

Asthma

X-ray Therapy

Pneumonia

Joint Replacement or Synthetic Implant

Convulsions or Epilepsy

Bleeding Problems

Lung Problems or Tuberculosis

Thyroid Disease

AIDS/HIV

Venereal Disease

Glaucoma

Ulcers

Arthritis

Blood Disease, i.e., Anemia

Sinus Trouble

Stomach, Intestinal Trouble

Circulatory Problems

Eye, Ear, Nose, Throat Trouble

Severe Headaches/Migraines

Females Only: Are you pregnant?

Are you Hearing Impaired?

Are you Allergic or Sensitive to: \_\_\_\_\_

YES NO

Penicillin

Aspirin

Codeine

Demerol

Local Anesthetic like Novocaine

Latex

Other Drugs, Medicines, or Foods (list)

Are you presently taking Medications? \_\_\_\_\_

YES NO

(if yes please list and give reason for taking)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

REMARKS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# DENTAL HEALTH

On a scale of 1-10 (10 being the highest) what priority do you give your teeth? \_\_\_\_\_

Name and address of former Dentist \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When was your last visit? \_\_\_\_\_ What was done at that time? \_\_\_\_\_

YES NO  
Are your teeth sensitive to sweets? Temperature?  
Have you been under regular care by a dentist?  
Do any of your teeth ache?  
Do your gums feel tender or swollen?  
Do you notice popping in your jaw?  
Have you had any teeth removed?  
Were there any complications involved afterwards?

YES NO  
Do you have any loose teeth?  
Do your gums bleed or have pain?  
Do you clench or grind your teeth?  
Have you had orthodontic treatment?  
Are you tense during dental visits?  
Are you happy with the appearance of your teeth?  
Rate your smile (1-10, with 10 being the highest)

1. What brought you to our office?  
\_\_\_\_\_  
\_\_\_\_\_

2. How do you feel we could help you?  
\_\_\_\_\_  
\_\_\_\_\_

YES NO  
Are you deeply concerned about the finances required to return your mouth to excellent dental health?  
Do you want to learn to control dental disease and retain your teeth?  
Do you feel you will eventually wear artificial dentures?

Why did you leave your last Dentist?  
\_\_\_\_\_

## CONSENT FOR PROCEDURE

I certify that all the above medical and dental information is true to my knowledge and I have not omitted any patient information. I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic and nitrous oxide as indicated. I understand that I will be informed of any treatment changes as they occur. I will assume responsibility for fees associated with all procedures and all costs incurred in the collection of those fees.

Patient's (Parent's) Signature \_\_\_\_\_ Date \_\_\_\_\_

If you wish to assign benefits available to you under your dental insurance policy, please sign:

\_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_