Patient Medical Information

PATIENT INFORMATION

Date: _____ Social Security #: _____

Patient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Sex: ❒ M ❒ F Age: _____ Birthdate: _____

❒ Married ❒ Widowed ❒ Single ❒ Minor ❒ Separated ❒ Divorced ❒ Partnered for _____ years

Occupation: _____ Patient Employer/School: _____

Employer/School Address: _____

Employer/School Phone: _____

Spouse or Parent's Name: _____

Birthdate: _____ Whom may we thank for referring you? _____

Spouse or Parent's Employer: _____

INSURANCE

Primary

Dental Insurance: ❒ Yes ❒ No Subscriber's Name: _____

Subscriber's Birthdate: _____ Subscriber's Employer: _____

Insurance Company: _____ Group #: _____ Contract #: _____

Secondary

Dental Insurance: ❒ Yes ❒ No Subscriber's Name: _____

Subscriber's Birthdate: _____ Subscriber's Employer: _____

Insurance Company: _____ Group #: _____ Contract #: _____

PHONE NUMBERS

Home: _____ Work: _____ Ext.: _____ Cell: _____

Spouse or Parent's Work: _____ Preferred Method of Contact: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

DENTAL HISTORY

Reason for today's visit: _____

_____

Former Dentist: _____

City/State: _____

Date of last dental visit: _____

Date of last dental X-rays: _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath ❒ Yes ❒ No

Bleeding gums ❒ Yes ❒ No

Blisters on lips or mouth ❒ Yes ❒ No

Burning sensation on tongue ❒ Yes ❒ No

Chew on one side of mouth ❒ Yes ❒ No

Cigarette, pipe, or cigar smoking ❒ Yes ❒ No

Clicking or popping jaw ❒ Yes ❒ No

Dry mouth ❒ Yes ❒ No

Fingernail biting ❒ Yes ❒ No

Food collection between the teeth ❒ Yes ❒ No

Grinding teeth ❒ Yes ❒ No

Gums swollen or tender ❒ Yes ❒ No

Jaw pain or tiredness ❒ Yes ❒ No

Lip or cheek biting ❒ Yes ❒ No

Loose teeth or broken fillings ❒ Yes ❒ No

Mouth breathing ❒ Yes ❒ No

Mouth pain, brushing ❒ Yes ❒ No

Orthodontic treatment ❒ Yes ❒ No

Pain around ear ❒ Yes ❒ No

Periodontal treatment ❒ Yes ❒ No

Sensitivity to cold ❒ Yes ❒ No

Sensitivity to heat ❒ Yes ❒ No

Sensitivity to sweets ❒ Yes ❒ No

Sensitivity when biting ❒ Yes ❒ No

Sores or growths in your mouth ❒ Yes ❒ No

Are you happy with the appearance of your smile? ❒ Yes ❒ No

How often do you floss? _____

How often do you brush? _____

HEALTH HISTORY

Physician's Name: _____ Date of last visit: _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Abnormal Bleeding, with extractions or surgery	❒ Yes	❒ No	Emphysema	❒ Yes	❒ No	Radiation Treatment	❒ Yes	❒ No
AIDS/HIV	❒ Yes	❒ No	Epilepsy	❒ Yes	❒ No	Respiratory Disease	❒ Yes	❒ No
Anemia	❒ Yes	❒ No	Fainting or Dizziness	❒ Yes	❒ No	Rheumatic Fever	❒ Yes	❒ No
Arthritis, Rheumatism	❒ Yes	❒ No	Glaucoma	❒ Yes	❒ No	Scarlet Fever	❒ Yes	❒ No
Artificial Heart Valves	❒ Yes	❒ No	Headaches	❒ Yes	❒ No	Shortness of Breath	❒ Yes	❒ No
Artificial Joints	❒ Yes	❒ No	Heart Murmur	❒ Yes	❒ No	Sinus Trouble	❒ Yes	❒ No
Asthma	❒ Yes	❒ No	Heart Problems	❒ Yes	❒ No	Skin Rash	❒ Yes	❒ No
Back Problems	❒ Yes	❒ No	Hepatitis			Special Diet	❒ Yes	❒ No
Blood Disease	❒ Yes	❒ No	Type _____	❒ Yes	❒ No	Stroke	❒ Yes	❒ No
Cancer	❒ Yes	❒ No	Herpes	❒ Yes	❒ No	Swollen Feet or Ankles	❒ Yes	❒ No
Chemical Dependency	❒ Yes	❒ No	High Blood Pressure	❒ Yes	❒ No	Swollen Neck Glands	❒ Yes	❒ No
Chemotherapy	❒ Yes	❒ No	Jaundice	❒ Yes	❒ No	Thyroid Problems	❒ Yes	❒ No
Circulatory Problems	❒ Yes	❒ No	Jaw Pain	❒ Yes	❒ No	Tonsillitis	❒ Yes	❒ No
Congenital Heart Lesions	❒ Yes	❒ No	Kidney Disease	❒ Yes	❒ No	Tuberculosis	❒ Yes	❒ No
Cortisone Treatments	❒ Yes	❒ No	Liver Disease	❒ Yes	❒ No	Tumor or Growth on head or neck	❒ Yes	❒ No
Cough, persistent or bloody	❒ Yes	❒ No	Low Blood Pressure	❒ Yes	❒ No	Ulcer	❒ Yes	❒ No
Diabetes	❒ Yes	❒ No	Mitral Valve Prolapse	❒ Yes	❒ No	Venereal Disease	❒ Yes	❒ No
			Nervous Problems	❒ Yes	❒ No	Weight Loss, unexplained	❒ Yes	❒ No
			Pacemaker	❒ Yes	❒ No			
			Psychiatric Care	❒ Yes	❒ No			

Women:

Are you pregnant? ❒ Yes ❒ No Due date: _____ Are you nursing? ❒ Yes ❒ No Are you taking birth control pills? ❒ Yes ❒ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnoses:

_____

_____

_____

Pharmacy Name: _____

Phone: _____

ALLERGIES

❒ Aspirin
❒ Barbiturates (sleeping pills)
❒ Codeine
❒ Other _____
❒ Local Anesthetic
❒ Penicillin
❒ Latex

PAYMENT OF FEES

Payment at the time of services is expected. For your convenience, we accept payment by credit cards. Our office will be happy to submit your claim to your insurance company. By signing this form, I acknowledge and understand that I am responsible for any amounts not covered by insurance for services rendered to me or my dependents. I

Signature: _____ Date: _____

You will be asked to sign this document upon arrival for your appointment.