

PATIENT INFORMATION

CONFIDENTIAL

PATIENT # _____

(PLEASE PRINT)

DATE _____

NAME _____ BIRTHDATE _____ HOME PHONE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

E-MAIL _____ CELL PHONE _____

CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED
PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE/PROV. _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ FINANCIAL INSTITUTION _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

X
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

SIGNATURE

PATIENT NAME _____
 HOME ADDRESS _____

 E-MAIL _____
 BUSINESS ADDRESS _____

TODAY'S DATE _____
 DATE OF BIRTH _____
 HOME PHONE _____
 CELL PHONE _____
 BUSINESS PHONE _____
 SS #/SIN _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

1. ARE YOU UNDER MEDICAL TREATMENT NOW? YES NO

2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? YES NO

3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? YES NO
 IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____

4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX? YES NO

5. DO YOU USE TOBACCO? YES NO

6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS? YES NO

7. ARE YOU WEARING CONTACT LENSES? YES NO

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?
 YES NO YES NO YES NO
 LOCAL ANESTHETICS (E.G. NOVOCAINE) BARBITURATES ASPIRIN
 PENICILLIN OR OTHER ANTIBIOTICS SEDATIVES OTHER
 SULFA DRUGS IODINE

9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)? YES NO

10. WOMEN ONLY:
 A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? YES NO
 B) ARE YOU NURSING? YES NO
 C) ARE YOU TAKING BIRTH CONTROL PILLS? YES NO

II. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> CHEST PAINS
<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> CARDIAC PACEMAKER	<input type="checkbox"/> EASILY WINDED
<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> STROKE
<input type="checkbox"/> SWOLLEN ANKLES	<input type="checkbox"/> ANGINA	<input type="checkbox"/> HAY FEVER / ALLERGIES
<input type="checkbox"/> FAINTING / SEIZURES	<input type="checkbox"/> FREQUENTLY TIRED	<input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> ANEMIA	<input type="checkbox"/> RADIATION THERAPY
<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> GLAUCOMA
<input type="checkbox"/> EPILEPSY / CONVULSIONS	<input type="checkbox"/> CANCER	<input type="checkbox"/> RECENT WEIGHT LOSS
<input type="checkbox"/> LEUKEMIA	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> LIVER DISEASE
<input type="checkbox"/> DIABETES	<input type="checkbox"/> JOINT REPLACEMENT OR IMPLANT	<input type="checkbox"/> HEART TROUBLE
<input type="checkbox"/> KIDNEY DISEASES	<input type="checkbox"/> HEPATITIS / JAUNDICE	<input type="checkbox"/> RESPIRATORY PROBLEMS
<input type="checkbox"/> AIDS OR HIV INFECTION	<input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> THYROID PROBLEM	<input type="checkbox"/> STOMACH TROUBLES / ULCERS	

COMMENTS

SIGNATURE OF DENTIST _____ DATE _____

PATIENT DENTAL HISTORY

1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? <input type="checkbox"/> YES <input type="checkbox"/> NO	8. DO YOU HAVE FREQUENT HEADACHES? <input type="checkbox"/> YES <input type="checkbox"/> NO
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? <input type="checkbox"/> YES <input type="checkbox"/> NO	9. DO YOU CLENCH OR GRIND YOUR TEETH? <input type="checkbox"/> YES <input type="checkbox"/> NO
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? <input type="checkbox"/> YES <input type="checkbox"/> NO	10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? <input type="checkbox"/> YES <input type="checkbox"/> NO
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? <input type="checkbox"/> YES <input type="checkbox"/> NO	11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST? <input type="checkbox"/> YES <input type="checkbox"/> NO
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? <input type="checkbox"/> YES <input type="checkbox"/> NO	12. HAVE YOU HAD ANY ORTHODONTIC WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? <input type="checkbox"/> YES <input type="checkbox"/> NO	13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW? A) CLICKING? <input type="checkbox"/> YES <input type="checkbox"/> NO B) PAIN (JOINT, EAR, SIDE OF FACE)? <input type="checkbox"/> YES <input type="checkbox"/> NO C) DIFFICULTY IN OPENING OR CLOSING? <input type="checkbox"/> YES <input type="checkbox"/> NO D) DIFFICULTY IN CHEWING? <input type="checkbox"/> YES <input type="checkbox"/> NO	14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? <input type="checkbox"/> YES <input type="checkbox"/> NO
	15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS? <input type="checkbox"/> YES <input type="checkbox"/> NO

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X

PATIENT, PARENT OR GUARDIAN

DATE