

PATIENT INFORMATION

Full Name: _____ SS# _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Home Phone: _____ Work #: _____ Cell# _____

Email Address: _____

Employer: _____ Address: _____

Spouse Name: _____ Employer: _____

Emergency Contact Person & Phone #: (exclude home #) _____

DENTAL INSURANCE

Dental Insurance Co: _____ Policy/Group # _____

Person Insured: _____ D.O.B.: _____ SS/ID# _____

Employer: _____ Relation to Patient: Self _____ Spouse _____ Child _____ Other _____

MEDICAL HISTORY

Medical Physician's Name: _____ Last Visit Date: (month/year) _____

Are you being treated now? _____ If Yes, Describe Condition: _____

Do you smoke: _____ If Yes, How Much Daily: _____

List ALL medicines and strength you take (Prescribed, Non-Prescribed, Herbal):

CIRCLE any of the following medications you should not take or that cause you problems:

Penicillin Demerol Codeine Ibuprofen Aspirin "Novacaine" Iodine
Sulfa Antibiotics (Type) _____ Other: _____

CIRCLE any of the following conditions that you have had in the past or presently have:

Latex Heart Disease Pacemaker Heart Murmur Osteoporosis Thyroid Condition
Sinusitis Stroke Ulcers Joint Replacement Asthma Sinus Problems
High BP Allergies Lung Problem Emphysema Glaucoma Hepatitis
Diabetes Cancer Radiation Psychological Care Kidney Disease Epilepsy
Tuberculosis AIDS (HIV) STD Arthritis

Dentist Who Recommended You See Us: _____

HISTORY FORM

OVER



CHECK YES OR NO	YES	NO	CHECK YES OR NO	YES	NO
Do you take Aspirin?			Bleed easily from cut?		
Do you take blood thinner?			Is general health good?		
Do you take Steroids?			Had significant weight loss?		
Health changed recently?			FEMALES ONLY		
Do you bruise easily?			Are you pregnant?		
Had major surgery?			Take oral contraceptives?		

Describe any current medical treatment or surgery planned:

Any specific facts we need to know: _____

DENTAL HISTORY

What dental problem brings you to see us for care?

Have you had any problem with typical dental anesthetic use? _____

Do have any discomfort when opening or closing your mouth? _____

Do you have soreness or tenderness in your jaw joints? _____

Are you aware of grinding or clenching your teeth? _____

Have you had jaw joint surgery of any kind? _____

Did either of your parents lose some or all of their teeth at a young age? _____

Have you noticed your teeth shifting or moving in position? _____

Have you had periodontal treatment in the past? _____ If yes, approximately when? _____

Previous periodontist you have consulted or been treated by? _____

Consent for Examination, X-Ray Diagnostic Series, Insurance Authorization/Pre-Estimates:

To my knowledge, the above information is correct to date. I authorize this practice to take diagnostic x-rays, models, photographs or other records to be used in the diagnosis and treatment of conditions found. I have received the notice of privacy practices required by HIPAA. I am informed and aware that I have the right to read the "Notice of Privacy Practices" before giving consent to use or disclose personal information to third party reimbursement, financing or other payment arrangement organizations.

I understand that I am solely responsible for any and all fees incurred in my treatment. I am aware that this practice will assist me in providing specific information to third party reimbursement and/or insurer organizations with my authorization to do so.

Signature and DATE of patient or responsible party: _____