

## PATIENT INFORMATION

Full Name: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell# \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer Name & Address \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact Person & Phone Number: (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) \_\_\_\_\_

Pharmacy Name & Phone Number: \_\_\_\_\_

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: \_\_\_\_\_

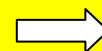
CIRCLE any of the following conditions that you have had in the past or presently have:

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? \_\_\_\_\_

Travel outside the U.S. in the last 6 months? If so, where \_\_\_\_\_

#### 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:** \_\_\_\_\_