

PATIENT INFORMATION AND HEALTH HISTORY

Date _____

PATIENT'S NAME: Dr Mr Mrs Ms Miss _____ DATE OF BIRTH _____
Last First Middle Initial

ADDRESS _____ HOME PHONE# _____
Number Street City Zip

SS# _____ DRIVER LICENSE# _____ DAYTIME / CELL PHONE# _____ EMAIL ADDRESS _____

REFERRED BY _____ EMPLOYED BY _____ BUSINESS PHONE# _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ SS# _____ DOB _____ RELATIONSHIP _____

DENTAL INSURANCE PLAN _____ PRIMARY CARD HOLDER'S NAME: _____ HIS/HER PHONE # _____

DENTAL HISTORY

CHIEF ORAL COMPLAINT _____

DATE OF LAST DENTAL EXAM _____ ANY PREVIOUS MAJOR DENTAL TREATMENT: NO or YES (WHEN _____,

TYPE OF TREATMENT _____)

PLEASE CHECK ALL THAT APPLY TO YOU WITH A (✓)

- Cosmetic concern (teeth not white/straight/pretty) _____ Pain around ear / TMJ problem Oral habits, i.e., fingernail biting, cheek biting, etc.
 Teeth sensitive to cold, heat, sweets or pressure Bad breath Cigarettes, Pipe or Cigar smoking / Tobacco chewing
 Bleeding gums. How frequent _____ Unpleasant taste Texture of toothbrush: soft / medium / hard
 Food impacting Mouth breathing Frequency of brushing: _____ times per day
 Clenching or Grinding Periodontal treatment year _____ Frequency of dental flossing: _____ times per day
 Burning of Tongue Orthodontic treatment year _____ Fluoride supplements
 Swelling or Lumps in mouth Complication from extractions Wearing dentures / partials
 Frequent blisters on lips or mouth Other dental treatment complication history _____

MEDICAL HISTORY

PHYSICIAN'S NAME _____ PHONE # _____ DATE OF LAST PHYSICAL EXAM _____ CURRENT AGE _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING - PLEASE CHECK ALL THAT APPLY TO YOU WITH A (✓)

- Allergies to latex / drugs / anesthetic list: _____ Eye disease / glaucoma
 Excessive bleeding from cut / extractions Joint Replacement of _____ year _____ Diabetes
 Anemia Thyroid disease _____ Heart attack, if so what year _____
 Heart valve replacement / defect type: _____ Cancer of _____ Pacemaker
 Rheumatic fever Radiation / Chemo treatments of _____ High blood pressure
 Pre medicate for dental procedures Gastric ulcer or Colitis Stroke (year occurred _____)
 Hepatitis A / B / C Kidney problems Seizure / Epilepsy
 HIV / AIDS Sinus problem Psychiatric care / emotional problem _____
 Tuberculosis Asthma Currently pregnant; If so, due ate _____
 Osteoporosis / Osteopenia Tonsillitis Others (describe: _____)
 List All Current Medicine that you are taking including over the counter meds: _____

APPOINTMENTS: A minimum of \$75 charge will be made for failed or cancelled appointment without prior notification of 48 hours (2 Business Days). Once an appointment is made, please remember this time has been reserved for you.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish our patients to know that we do not render our services on the basis that insurance companies will pay all dental services. Each dental treatment plan is individualized for the individual patient. All professional services rendered are charged directly to the patients and that patients are personally responsible for payment of all fees. However, we will prepare necessary forms or reports to help you obtain your insurance benefits.

THANK YOU FOR CHOOSING US AS YOUR DENTAL HEALTH PROVIDER!!!

SIGNATURE _____ DATE _____

(Parent or guardian if patient is a minor)

(Form 01/11)