

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 _____

	YES	NO		YES	NO	YES	NO	YES	NO			
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	<input type="checkbox"/>	<input type="checkbox"/>	8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?	<input type="checkbox"/>	<input type="checkbox"/>	LOCAL ANESTHETICS (E.G. NOVOCAINE)	<input type="checkbox"/>	BARBITURATES	<input type="checkbox"/>	ASPIRIN	<input type="checkbox"/>	<input type="checkbox"/>
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	PENICILLIN OR OTHER ANTIBIOTICS	<input type="checkbox"/>	SEDATIVES	<input type="checkbox"/>	OTHER	<input type="checkbox"/>	<input type="checkbox"/>
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	SULFA DRUGS	<input type="checkbox"/>	IODINE	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____			9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)?	<input type="checkbox"/>	<input type="checkbox"/>					YES	NO	
4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	<input type="checkbox"/>	<input type="checkbox"/>	10. WOMEN ONLY:									
5. DO YOU USE TOBACCO?	<input type="checkbox"/>	<input type="checkbox"/>	A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>							
6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	<input type="checkbox"/>	<input type="checkbox"/>	B) ARE YOU NURSING?	<input type="checkbox"/>	<input type="checkbox"/>							
7. ARE YOU WEARING CONTACT LENSES?	<input type="checkbox"/>	<input type="checkbox"/>	C) ARE YOU TAKING BIRTH CONTROL PILLS?	<input type="checkbox"/>	<input type="checkbox"/>							

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

YES	NO	YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE		HEART DISEASE		CHEST PAINS	
HEART ATTACK		CARDIAC PACEMAKER		EASILY WINDED	
RHEUMATIC FEVER		HEART MURMUR		STROKE	
SWOLLEN ANKLES		ANGINA		HAY FEVER / ALLERGIES	
FAINING / SEIZURES		FREQUENTLY TIRED		TUBERCULOSIS	
ASTHMA		ANEMIA		RADIATION THERAPY	
LOW BLOOD PRESSURE		EMPHYSEMA		GLAUCOMA	
EPILEPSY / CONVULSIONS		CANCER		RECENT WEIGHT LOSS	
LEUKEMIA		ARTHRITIS		LIVER DISEASE	
DIABETES		JOINT REPLACEMENT OR IMPLANT		HEART TROUBLE	
KIDNEY DISEASES		HEPATITIS / JAUNDICE		RESPIRATORY PROBLEMS	
AIDS OR HIV INFECTION		SEXUALLY TRANSMITTED DISEASE		OTHER _____	
THYROID PROBLEM		STOMACH TROUBLES / ULCERS			

COMMENTS

SIGNATURE OF DENTIST _____ DATE _____

PATIENT DENTAL HISTORY

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

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 _____