PATIENT INFORMATION

CONFIDENTIAL

PATIENT # _____

DATE _____

PLEASE FILL IN ALL APPLICABLE FIELDS

NAME _____ BIRTH DATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

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

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

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY

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

ADDRESS _____ HOME PHONE _____

SOCIAL SECURITY NUMBER _____

EMPLOYER _____ WORK PHONE _____

ADDRESS _____

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

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTH DATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION/LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

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 _____

BIRTH DATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION/LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

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

_____

X SIGNATURE OF PATIENT OR PARENT, IF MINOR

PATIENT NAME

PATIENT NAME _____ TODAY'S DATE _____

HOME ADDRESS _____ DATE OF BIRTH _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

CITY _____ STATE _____ ZIP _____ SOC. SEC. NO. _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION FOR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____	☐	☐
4. DO YOU USE TOBACCO?	☐	☐
5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	☐	☐
6. ARE YOU WEARING CONTACT LENSES?	☐	☐

7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS? IF YES, PLEASE SPECIFY.

8. WHEN WAS YOUR LAST COMPLETE PHYSICAL?

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

10. PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

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

COMMENTS

PATIENT DENTAL HISTORY

PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOOD?	☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUID/FOODS?	☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN YOUR EAR OR MOUTH?	☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?	
A) CLICKING?	☐
B) PAIN (JOINT, EAR, SIDE OF FACE)?	☐
C) DIFFICULTY IN OPENING OR CLOSING)?	☐
D) DIFFICULTY IN CHEWING?	☐
8. DO YOU HAVE FREQUENT HEADACHES?	☐
9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐
10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐
11. HAVE YOU EVER HAD ANY DIFFICULTY EXTRACTIONS IN THE PAST?	
12. HAVE YOU HAD ANY ORTHODONTIC WORK?	☐
13. HAVE YOU HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	☐
15. HAVE YOU EVER HAD INSTRUCTION ON THE CARE OF YOUR GUMS?	☐

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 _____

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