PATIENT INFORMATION AND HEALTH HISTORY

Patient's Name: _____ Date of Birth: _____

(Male ____ Female ____) Martial Status: Single _____ Married_____ Separated_____ Widowed_____

Referred By: _____ **Patient's SSN:** _____

Patient's Physical Address: _____

Patient's Mailing Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

Emergency Contact: _____ Phone: _____

Employer: _____ Business Address: _____

Person Responsible for this Account: _____ Address: _____

IF YOU HAVE DENTAL INSURANCE:

Name of Insurance Company: _____

Name of Insured: _____

Policy Number: _____

Dental History

Reason for today's visit: _____

Previous dentist- Name, city & phone no: _____

Date of last dental exam: _____ Any previous major dental treatment? YES NO When?_____

Have you ever been told you need to take an antibiotic before dental treatment? YES NO

Are you satisfied with the color of your teeth? YES NO

Are you happy with the position of your teeth? YES NO

Are you interested in cosmetic dentistry? YES NO

Are you interested in veneers? YES NO

Are you interested in orthodontic treatment? YES NO

Do you Have A History of Any of the Following? Circle if any apply

Tooth sensitive to cold, heat, sweets or pressure
Bleeding Gums How Long?_____
Food Impaction between teeth
Clenching or Grinding
Burning of Tongue
Swelling or lumps in mouth
Frequent blisters on lips or mouth
Pain around Ear
Unusual sounds in ear while eating

Bad Breath
Unpleasant taste
Unfavorable dental experience
Complications from extractions
Periodontal treatment
Orthodontic treatment
Mouth Breathing
Oral habits i.e. fingernail biting, cheek biting, etc.

Cigarettes, pipe or cigar smoking
Texture of toothbrush: soft or medium
Frequency of brushing: _____
Flossing
Inter-dental stimulators
Water jet devices
Disclosing tablets or solutions
Fluoride supplements
TMJ (temporal mandibular joint disorder)

Medical History

Physicians name: _____Phone: _____ Date of last physical exam: _____

Are you on any medications now? YES NO If yes, please list:_____

_____

_____

Do You Have Or Have You Had Any Of The Following? Circle if any apply

Allergies to drugs: _____
Allergies to anesthetics
Latex Allergy
Pretreatment antibiotics
Artificial joints pins, plates, screws
Rheumatic Fever
Artificial Heart Valves
Any Heart Ailments
Heart Murmur
High Blood Pressure
Neurological Problems
Excessive bleeding from cut or extraction
Asthma

Pacemaker
Anemia or blood problems
Diabetes
Kidney Problems
Liver Problems
Hepatitis
Cancer
Psychiatric Care/Emotional Problems
Epilepsy
Colostomy
Radiation treatments
Chemotherapy or Dialysis Port
Hay Fever or allergies in general

Stroke
Thyroid
AIDS/HIV+
Tuberculosis
Ulcer or colitis
Are you Pregnant?
If so what month _____
Venereal Disease
High Cholesterol
Ever taken medication for osteoporosis
History of Chemical Dependency

Additional information about your health status we should know about? _____

_____

Signature: _____ Date: _____

(parent or guardian, if patient is a minor)