

PATIENT INFORMATION

NAME _____ NICKNAME _____ BIRTHDATE _____
ADDRESS _____

(STREET) (CITY) (ZIP)
HOME PHONE _____ CELL PHONE _____ EMAIL _____
OCCUPATION _____ PLACE OF EMPLOYMENT _____
WORK PHONE _____ EXT. _____

REFERRED BY _____

IN CASE OF EMERGENCY, PERSON(S) TO CONTACT:

(1) NAME _____ RELATIONSHIP TO PATIENT _____ PHONE _____
(2) NAME _____ RELATIONSHIP TO PATIENT _____ PHONE _____

BILLING INFORMATION

RESPONSIBLE PARTY _____ BIRTHDATE _____
ADDRESS _____
(IF DIFFERENT FROM ABOVE) (STREET) (CITY) (ZIP)
RELATIONSHIP TO PATIENT _____
HOME PHONE _____ CELL PHONE _____ EMAIL _____
EMPLOYER _____ WORK PHONE _____ EXT. _____

INSURANCE INFORMATION-PRIMARY

INSURANCE INFORMATION-SECONDARY

DENTAL INSURANCE _____
EMPLOYER _____
GROUP NUMBER _____
RELATIONSHIP TO PATIENT _____
INSURED SSN _____
INSURED DOB _____

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EMPLOYER _____
GROUP NUMBER _____
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INSURED DOB _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any dentist, physician, hospital, pharmacy, insurance company, employer or insuring organization to release any information regarding my dental history, treatment or benefits payable for this claim for the purpose of validating and determining benefits payable in connection with this claim. This authorization or copy of the original shall be valid for the duration of the patient's relationship with this practice or until the information contained within changes.

AUTHORIZATION TO PAY BENEFITS TO THE DENTIST: I hereby certify to the above statements. I hereby authorize payment directly to the above named dentist of the group benefits otherwise payable to me.

SIGNATURE _____ DATE _____

MEDICAL HEALTH

In order to help us render the proper dental service to you, please complete the following questionnaire. Please note the space for any answers that require clarification or any other information you think we should have. Thank you for your cooperation.

Name of Family Physician _____ Phone _____

Physician Address _____

Last complete physical _____

List any medical specialists caring for you: cardiologist, orthopedist, pulmonary, oncologist, infectious disease

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Name of Pharmacy _____ Phone _____

Has any physician advised you to take antibiotics prior to dental care? _____

List all medications you are currently taking _____

Have you ever been hospitalized? Yes ___ No ___ For what? _____

Have you had or do you presently have any of the following conditions: **PLEASE CIRCLE**

HEART DISEASE

HEART SURGERY

HEART VALVE DEFECT

MITRAL VALVE DEFECT

RHEUMATIC FEVER

PROSTHETIC HEART VALVE

PACE MAKER

HIGH BLOOD PRESSURE

LOW BLOOD PRESSURE

STROKE

FAMILY HISTORY OF

HEART DISEASE, STROKE, CANCER

BRAIN INJURY

EPILEPSY, SEIZURES, CONVULSIONS

AUTISM

EMOTIONAL DISTURBANCE

THYROID DISEASE

CANCER, HYPOACTIVE, HYPERACTIVE

GRAVES DISEASE, HASHIMOTO'S DISEASE

PROLONGED BLEEDING

BLOOD DISEASE

SICKLE CELL DISEASE OR TRAIT

HEMOPHILIA

BLOOD TRANSFUSIONS

HTLV-III/AIDS/AIDS RELATED COMPLEX

TUMORS, GROWTHS (BENIGN, MALIGNANT)

CANCER/RADIATION THERAPY

DESCRIBE _____

ARTHRITIS

PROSTHETIC JOINTS: HIPS, KNEES

has your doctor prescribed antibiotics for the above?

DRUG/ALCOHOL ADDICTION

HEPATITIS: TYPE A, B, C, D, E, F, G

DIABETES

Glycohemoglobin _____

SEXUALLY TRANSMITTED DISEASE

SPINA BIFIDA

HEARING OR SPEECH DISORDER

KIDNEY PROBLEMS

GASTROINTESTINAL DISEASE

GERD, CROHN'S, IBS, CELIAC DISEASE

JAUNDICE, LIVER DISEASE

HIVES

CLEFT PALATE, CLEFT LIP

LUNG DISEASE

PNEUMONIA

TUBERCULOSIS/PPD+

EMPHYSEMA

COPD

ASTHMA: MILD, MODERATE, SEVERE

EATING DISORDERS: ANOREXIA, BULIMIA

SLEEPING DISORDERS

EYE DISORDER

VISUAL IMPAIRMENT, GLAUCOMA

Have you ever had an unusual reaction to or are you allergic to any of the following medications?

PLEASE CIRCLE

Dental Anesthetics

Penicillin

Latex

Aspirin Compounds

Erythromycin

Foods _____

Codeine Compounds

Amoxicillin

Seafood

Iodine

Other _____

Do you smoke? _____ What? _____ How much? _____

Have you thought about quitting? _____ Have you tried to quit? _____

Do you use alcohol? _____ How much? _____ How often? _____ What? _____

Women: Are you pregnant? _____ If yes, estimated delivery date _____

Are you breast-feeding? _____ Are you taking birth control pills? _____

DENTAL HEALTH

Reason for visit _____

When was your last dental visit? _____

Have you ever had any serious problems associated with previous dental treatment? Yes__No__
 If so, explain _____

How often do you brush your teeth? _____

What texture toothbrush do you use? Soft__Medium__Hard__Nylon__Natural__

How often do you floss? _____

Do your gums bleed while brushing? Yes__No__

Do your gums bleed while flossing? Yes__No__

Do you avoid brushing any part of your mouth because of pain? Yes__No__
 If yes, where? _____

Do you feel twinges of pain when you teeth come in contact with:
 a. Hot foods or liquids i.e. – soup/coffee/tea? Yes__No__
 b. Cold foods or liquids i.e. – ice cream/cold fruit? Yes__No__
 c. Sweets i.e. – candy/fruit/sweet desserts? Yes__No__
 d. sours i.e. – lemons/limes/grapefruit? Yes__No__

Do you feel pain with any teeth when brushing or flossing? Yes__No__

Do you chew on only one side of your mouth? Yes__No__
 If yes, explain _____

Do your gums feel tender or swollen? Yes__No__

Do you clench or grind your jaws while sleeping or during the day? Yes__No__

Do your jaws ever feel tired? Yes__No__

Do you wear dentures? Yes__No__

Do you usually have many cavities? Yes__No__

Do you gag easily? Yes__No__

Have you ever had prolonged bleeding following extractions? Yes__No__

When were your last full mouth x-rays taken? _____
 Where? _____

Do you think your teeth are affecting your general health in any way? Yes__No__
 If so, how? _____

Are you dissatisfied with the appearance of you teeth? Yes__No__

Are you worried about receiving dental treatment? Yes__No__

Do you have difficulty chewing your food? Yes__No__

Do you have frequent canker sores or cold sores? Yes__No__

Please add anything you feel is important _____

BP

PULSE

 Patient signature Date
 (parent or guardian must sign if patient is under 18)

DOCTOR SIGNATURE