MEDICAL HISTORY

CONFIDENTIAL

Name: _____

Physician's Name: _____ City: _____ Date of last physical: _____
MEDICAL)

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

	(Circle One)			(Circle One)			(Circle One)	
Heart Murmur	Yes	No	Blood disease	Yes	No	Respiratory Disease	Yes	No
Mitral valve prolapse	Yes	No	Anemia	Yes	No	Asthma	Yes	No
Artificial joint(s)	Yes	No	Excessive bleeding	Yes	No	Emphysema	Yes	No
Artificial heart valve(s)	Yes	No	Sickle cell disease	Yes	No	Tuberculosis	Yes	No
Rheumatic fever	Yes	No	Hemophilia	Yes	No	Breathing problem	Yes	No
Heart trouble/disease	Yes	No	Leukemia	Yes	No	Shortness of breath	Yes	No
Irregular heart beat	Yes	No	Recent blood transfusion	Yes	No	Frequent cough	Yes	No
Angina/chest pain	Yes	No	Cancer	Yes	No	Kidney problems	Yes	No
Scarlet fever	Yes	No	Chemotherapy	Yes	No	Thyroid problems	Yes	No
Heart pace maker	Yes	No	X-ray treatment (radiation)	Yes	No	Parathyroid disease	Yes	No
Heart surgery	Yes	No	Stomach/intestinal disease	Yes	No	Liver disease	Yes	No
Heart attack/failure	Yes	No	Ulcers	Yes	No	Hepatitis A (Infectious)	Yes	No
High blood pressure	Yes	No	Diabetes	Yes	No	Hepatitis B (serum)	Yes	No
Low blood pressure	Yes	No	Hypoglycemia	Yes	No	Yellow jaundice	Yes	No
Allergies	Yes	No	Psychiatric care	Yes	No	Tumors or growths	Yes	No
to anesthetic	Yes	No	Alzheimer's disease	Yes	No	Oral herpes	Yes	No
to acrylic	Yes	No	Nervousness	Yes	No	Genital herpes	Yes	No
to metal	Yes	No	Chronic depression	Yes	No	Venereal disease	Yes	No
to latex	Yes	No	Stroke	Yes	No	Cold sores	Yes	No
Hay fever	Yes	No	Epilepsy/seizures	Yes	No	Fever blisters	Yes	No
Sinus trouble	Yes	No	Back problems	Yes	No	Chemical dependency	Yes	No
Recent weight loss/gain	Yes	No	Arthritis/gout	Yes	No	AIDS	Yes	No
Frequent diarrhea	Yes	No	Rheumatism	Yes	No	HIV positive	Yes	No

Please give details of any of the conditions listed "yes" above: _____

_____

Do you have any drug allergies or have you ever had an adverse reaction to any medication? Yes ___ No ___

f you have, please list drug/medication: _____

Have you ever had any other serious illness not listed above? Please discuss: _____

_____

Are you taking any medication(s) at this time? Is so, please list:

Medication	**Condition**
_____	_____
_____	_____
_____	_____
_____	_____

WOMEN:

Do you suspect that you are pregnant? Yes ___ No ___ If yes, when are you due? _____

Are you nursing? Yes ___ No ___ *Note: There are drugs and medications used in routine dental*

Are you taking birth control pills? Yes ___ No ___ *care that decrease the effectiveness of birth control*

he above information is accurate and complete to the best of my knowledge and is only for use in my treatment. There are many drug and medication ncompatabilities, some of which may result in dangerous health problems. Information about your current use of drugs & medication is essential. I will not hold my dentist or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

SIGNATURE: _____ DATE: _____

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WELCOME TO OUR PRACTICE!

Thank you for selecting our dental healthcare team. Please fill out (please print) this form completely. If you have any questions or concerns, please ask our staff for assistance as we would be happy to help.

Patient Information

E-Mail: _____

Soc Sec. # _____

Name: _____ Birthdate: _____ Home Phone: _____

Preferred Name: _____ Age: _____ Sex: ❑ Female ❑ Male Cell Phone: _____

Home Address _____ City _____ State _____ Zip _____

Do You Prefer to Receive Calls at: ❑ Home ❑ Work ❑ Either Convenient time to call: _____ AM/PM

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 _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Relationship to patient _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Employer _____ Work Phone _____

Is this Person Currently a Patient in our Office? ❑ Yes ❑ No Birthdate _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Soc. Security # _____ Date employed _____

Name of Employer _____ Work Phone _____

Address of employer _____ City _____ State _____ Zip _____

Insurance company _____ Group # _____ Union or Local # _____

Ins. Company Address _____ City _____ State _____ Zip _____

Phone _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ❑ **Yes** ❑ **No** **IF YES , COMPLETE THE FOLLOWING:**

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Soc. Security # _____ Date employed _____

Name of Employer _____ Work Phone _____

Address of employer _____ City _____ State _____ Zip _____

Insurance company _____ Group # _____ Union or Local # _____

Ins. Company Address _____ City _____ State _____ Zip _____

Authorization and Release: I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or Parent if Minor) _____ Date _____

PATIENT REGISTRATION

DENTAL HISTORY

CONFIDENTIAL

WELCOME! So that we may provide you with the best possible dental care, please complete this dental history form. All information is completely confidential.

Name: _____ Date: _____

Previous dentist's name: _____ May we contact her/him? Yes ___ No ___

City: _____

Date of last dental visit: _____ What was done? _____

Date of most recent full mouth x-rays (16-18 films): _____

Date of last dental cleaning: _____

How often do you have dental examinations? _____

In a day, how many times do you brush your teeth? _____

How often do you floss? _____

What other dental aids do you use? (electric toothbrush, toothpick, etc.) _____

Do you have any dental problems at this time? Yes ___ No ___

If yes, please describe: _____

ARE ANY OF YOUR TEETH SENSITIVE TO: (Circle One)

Hot or cold? . . . . . Yes No

Sweets? . . . . . Yes No

Biting or chewing? . . . . . Yes No

Have you noticed any mouth odors or bad tastes? . . Yes No

Do you frequently get cold sores, blisters, or other oral lesions?. . . . . Yes No

Do your gums ever bleed or hurt?. . . . . Yes No

HAVE YOU EVER HAD: (Circle One)

Orthodontic treatment? . . . . . Yes No

Oral surgery? . . . . . Yes No

Periodontic treatment? (bones & gums) . . . . . Yes No

Your teeth ground or your bite adjusted?. . . . . Yes No

A biteplane or a mouthguard?. . . . . Yes No

A serious injury to your mouth or head? . . . . . Yes No

If yes , please describe: _____

_____

Have your parents experienced gum disease or tooth loss?. . . . . Yes No

Have you noticed any loose teeth or change in your bite?. . . . . Yes No

Does food tend to become caught in between your teeth? If yes, where? _____ . . Yes No

HAVE YOU EXPERIENCED:

Clicking or popping of the jaw? . . . . . Yes No

Pain? (joint, ear, side of the face, etc.) . . . . . Yes No

Difficulty in opening or closing the mouth? . . . . . Yes No

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neckaches or shoulder aches? . . . . Yes No

Sore muscles? (neck, shoulders, etc.) . . . . . Yes No

DO YOU:

Snore heavily? . . . . . Yes No

Clench or grind your teeth while awake or asleep? . . Yes No

Bite your lips or cheeks regularly? . . . . . Yes No

Hold foreign objects with your teeth? . . . . . Yes No (pencils, pipe, fingernails, etc.)

Mouth breathe while asleep . . . . . Yes No

Have tired jaws, especially in the morning? . . . . . Yes No

Smoke / chew tobacco? . . . . . Yes No

If yes, how much? _____

ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH? . . . . . Yes No

If no, please explain: _____

Do you feel nervous about having dental treatment? Yes No

If yes, what is your biggest concern? _____

_____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe: _____

_____

IS THERE ANYTHING ELSE ABOUT HAVING DENTAL TREATMENT THAT YOU WOULD LIKE US TO KNOW?

Yes ___ No ___ If yes, please describe: _____

_____