



PATIENT INFORMATION – CONFIDENTIAL

Name: FIRST MI LAST Birth Date: Social Security #

Circle your current marital status: Single Married Divorced Domestic Partner

Address: STREET CITY STATE ZIP CODE

Home Phone: Cell Phone:

Employer: Work Phone: EXT.:

Person to Contact in Case of Emergency: Phone:

Are you Solely Responsible for this account? YES NO

If NO list Responsible Party: Phone #:

Responsible Parties Address if different than yours: STREET CITY STATE ZIP

INSURANCE INFORMATION

Name of Insured: Relationship to You:

Insured Parties ID # or Social Security #: Birth Date:

Insurance Company: Group #:

Insurance Co. Phone Number #:

DENTAL HISTORY

- Do your gums bleed while brushing or flossing? Yes No
Are your teeth sensitive to Hot or Cold liquids/foods? Yes No
Are your teeth sensitive to Sweet or Sour liquids/foods? Yes No
Do you feel pain in any of your teeth? Yes No
Do you have any sores or lumps in or near your mouth? Yes No
Have you had any head, neck or jaw injuries? Yes No
Do you have frequent headaches? Yes No
Do you clench or grind your teeth? Yes No
Have you had difficulty with previous extractions? Yes No
Have you had prolonged bleeding after an extraction? Yes No
Have you had orthodontic (braces) work done? Yes No
Have you been instructed in the correct brushing techniques? Yes No

Circle any that you have experienced: Clicking Pain Difficulty opening or closing Difficulty chewing

I have read and answered the above questions to the best of my knowledge. I authorize my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance.

SIGNATURE of PATIENT or parent if a minor

DATE

## MEDICAL HISTORY - Please read carefully and be thorough, Thank You.

Please check all that apply, circle where appropriate and write in the type

- |   |  |
|---|--|
| <input type="checkbox"/> Heart Failure                    | <input type="checkbox"/> Jaundice                          |
| <input type="checkbox"/> Heart Attack                     | <input type="checkbox"/> Hepatitis A B C                   |
| <input type="checkbox"/> Angina Pectoris                  | <input type="checkbox"/> Liver / Kidney / Heart Transplant |
| <input type="checkbox"/> High Blood Pressure              | <input type="checkbox"/> Venereal Disease - Type:          |
| <input type="checkbox"/> Low Blood Pressure               | <input type="checkbox"/> Cold Sores                        |
| <input type="checkbox"/> High Cholesterol                 | <input type="checkbox"/> Positive Test for HIV             |
| <input type="checkbox"/> Heart Murmur                     | <input type="checkbox"/> Chemotherapy                      |
| <input type="checkbox"/> Scarlet Fever                    | <input type="checkbox"/> Radiation Treatment               |
| <input type="checkbox"/> Rheumatic Fever                  | <input type="checkbox"/> Cancer – Type:                    |
| <input type="checkbox"/> Mitral Valve Prolapse            | <input type="checkbox"/> Unexplained Weight Loss           |
| <input type="checkbox"/> Heart Pacemaker                  | <input type="checkbox"/> Tumor – Type:                     |
| <input type="checkbox"/> Heart Surgery                    | <input type="checkbox"/> Special Diet                      |
| <input type="checkbox"/> Artificial valve / stent         | <input type="checkbox"/> Stroke / TIA                      |
| <input type="checkbox"/> Congenital Heart Lesion          | <input type="checkbox"/> Epilepsy                          |
| <input type="checkbox"/> Anemia – Type:                   | <input type="checkbox"/> Seizures                          |
| <input type="checkbox"/> Blood Disease - Type:            | <input type="checkbox"/> Headaches                         |
| <input type="checkbox"/> Circulatory Problems             | <input type="checkbox"/> Nervous Problems                  |
| <input type="checkbox"/> Emphysema                        | <input type="checkbox"/> Psychiatric Care                  |
| <input type="checkbox"/> Chronic cough                    | <input type="checkbox"/> Fainting / Dizzy Spells           |
| <input type="checkbox"/> Shortness of breath              | <input type="checkbox"/> Ulcers                            |
| <input type="checkbox"/> Tuberculosis / Positive PPD test | <input type="checkbox"/> Arthritis                         |
| <input type="checkbox"/> Asthma                           | <input type="checkbox"/> Artificial Joint                  |
| <input type="checkbox"/> Hay Fever                        | <input type="checkbox"/> Rheumatism                        |
| <input type="checkbox"/> Hives                            | <input type="checkbox"/> Blood Transfusion / Dialysis      |
| <input type="checkbox"/> Respiratory Disease - Type:      | <input type="checkbox"/> Blood/Thinners (Coumadin)         |
| <input type="checkbox"/> Diabetes Type I Type II          | <input type="checkbox"/> Aspirin taken daily               |
| <input type="checkbox"/> Thyroid Disease Hyper Hypo       | <input type="checkbox"/> Other – Please Explain: _____     |
| <input type="checkbox"/> Liver Disease                    |  |

Please list any diseases, conditions or surgeries you have or had that are not listed above.

## ALLERGIES - Check all that apply – Thank You!

Please check all that apply, circle where appropriate and write in the type

- |   |  |
|---|--|
| <input type="checkbox"/> Local Anesthetics        | <input type="checkbox"/> Sedatives     |
| <input type="checkbox"/> Penicillin / Antibiotics | <input type="checkbox"/> Iodine        |
| <input type="checkbox"/> Sulfa drugs              | <input type="checkbox"/> Aspirin       |
| <input type="checkbox"/> Barbiturates             | <input type="checkbox"/> Chocolate     |
| <input type="checkbox"/> Latex                    | <input type="checkbox"/> Other - _____ |
| <input type="checkbox"/> No allergies             |  |

You made it to the bottom of the form... You're almost done! Please flip this page over... Thanks!

Please check all that apply, circle where appropriate and write in the type

When you walk upstairs / take a walk do you have to stop due to pain in your chest, shortness of breath or fatigue? Yes No

Do you bruise easily? Yes No

Have you ever had excessive bleeding requiring special treatments? Yes No

Do you use tobacco products? Yes No

Do you use recreational drugs? Yes No

Are you pregnant? Yes No

Are you nursing? Yes No

Are you taking Birth Control Pills? Yes No

Do you have osteoporosis or have you ever taken the following: (please circle all that apply)

Fosamax | Didronel | Boniva | Actonel | Skelid | Zometa | Aredia

Medical Doctors Name:

Phone #:

**CURRENT MEDICATIONS** Please include all prescribed, over the counter, herbal supplements and vitamins

1	6	11	16
2	7	12	17
3	8	13	18
4	9	14	19
5	10	15	20

Patient or Guardian Signature

Date

For Office Use Only: BP

ASA Class I II III IV

Doctor Signature: