PATIENT INFORMATION AND HEALTH HISTORY

INITIAL EXAM DATE _____

PATIENT'S NAME _____ DATE OF BIRTH _____

SINGLE MARRIED DIVORCED SEPARATED WIDOWED

PATIENT'S ADDRESS _____ PATIENT'S PHONE ( ) _____

CITY _____ STATE _____ ZIP _____

EMPLOYED BY _____ BUSINESS PHONE _____

BUSINESS ADDRESS _____ PATIENT'S SS # _____

DENTAL INSURANCE PLAN (IF ANY) _____ REFERRED BY _____

PATIENT'S NAME

DENTAL HISTORY

CHIEF ORAL COMPLAINT _____

DATE OF LAST DENTAL EXAM. _____ ANY PREVIOUS MAJOR DENTAL TREATMENT, ☐ YES ☐ NO WHEN _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING - INDICATE WITH A (✔)

- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums. How long _____
- ☐ Food impaction
- ☐ 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 _____
- ☐ Frequency of brushing _____
- ☐ Dental Floss
- ☐ Inter dental stimulators
- ☐ Water jet device
- ☐ Disclosing tablets or solution
- ☐ Fluoride supplements

MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM. _____ AGE _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING - INDICATE WITH A (✔)

- ☐ Allergies to drugs
- ☐ Allergies to anesthetics
- ☐ Any heart ailments
- ☐ High blood pressure
- ☐ Neurological problems
- ☐ Radiation treatments
- ☐ Excessive bleeding from cut or extraction
- ☐ Anemia or blood problems
- ☐ Arthritis
- ☐ Asthma
- ☐ Hay fever or allergies in general
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Liver problems or hepatitis
- ☐ Malignancies
- ☐ Psychiatric care/emotional problems
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Immune System Disorders (AIDS, HIV, ARC)
- ☐ Stroke
- ☐ Thyroid
- ☐ Eye disorders
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer or colitis
- ☐ Pregnancy
  If so, what month _____
- ☐ Venereal disease
- ☐ Other _____

Describe any current medical treatment including drugs taken, even though not listed above _____

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

SIGNATURE _____ DATE _____
(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)

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