PATIENT INTRODUCTION

Who may we thank for referral? _____

PATIENT

Mr.
Mrs.
Miss _____
Patient name - last, first, middle

_____
social security # birthdate sex marital status home phone #

_____
address street apt # city state zip

_____
employed by employers address occupation bus. phone

_____
spouse's name employed by employers address

_____
spouse's occupation bus. phone soc. sec. # birthdate

RESPONSIBLE PARTY

Please complete the section below, if someone other than the patient is responsible for the payment of services. The policy of our office is the parent who requests treatment for the child is responsible for all fees for services rendered.

father's name _____
last first middle soc. sec. # birthdate

home address _____
street apt # city state zip phone

where employed _____ address _____

occupation _____ bus. phone # _____

mother's name _____
last first middle soc. sec. # birthdate

home address _____
street apt # city state zip phone

where employed _____ address _____

occupation _____ bus. phone # _____

DENTAL INSURANCE INFORMATION

(Be sure all information is listed)

INSURANCE

	Insurance Co. Name	Policyholder (self, spouse, parent)	Policy, Group, or Certificate #
1.			
2.			
3.			

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services. It is the policy of this office that payment or, if dental insurance, co-payment is expected at time of service, unless other arrangements are made.

_____
date (today) signature of patient, or parent or responsible party

PATIENT MEDICAL HISTORY FORM

The following information is to be reviewed by the doctor and will be held in strictest confidence. It is important that you complete this medical history form in its entirety so that we may accurately diagnose and treat you, according to your general health and well-being.

If you have any questions or require assistance in completing this medical history form, please ask our staff to help. Please return this completed form to the receptionist. Thank you for allowing us to serve your dental health care needs.

GENERAL MEDICAL HISTORY

	YES	NO
Are you presently in good health?	○	○
Are you presently under the care of a physician?	○	○

If yes, what is the condition or nature of illness?

_____

_____

Name, phone and address of your physician:

_____

_____

_____

Date of your last physical exam:

_____/_____/_____/_____/_____

Have you been hospitalized or had a major illness, operation or injury in the last 5 years?	○	○

If yes, please explain:

_____

_____

Please list all medications you are currently taking, including over-the-counter drugs:

_____

_____

_____

_____

Allergies to anesthetics?	○	○
Allergies to medicines or drugs?	○	○

If yes, name them:

_____

_____

FOR WOMEN ONLY: Is there a possibility you may be pregnant? YES ○ NO ○

If yes, give due date:

_____

Are you nursing? YES ○ NO ○

Have you been exposed to any of the following diseases?

• AIDS	○	○
• Herpes	○	○
• Mononucleosis	○	○
• Respiratory illnesses	○	○
• Hepatitis	○	○
What type? _____		
• Tuberculosis	○	○

Have you lost 10 or more pounds in the last 6 months without dieting?	○	○
Do you have any sores in your mouth or on other parts of your body?	○	○
Do you drink alcohol?	○	○

If yes, how often?

_____

Do you use tobacco products?	○	○

If so, how much? What form?

_____

Do you tire easily?	○	○
Do you have night sweats?	○	○
Do you have persistent fevers?	○	○
Prolonged cough 3-4 weeks or longer?	○	○
Bloody cough?	○	○

DENTAL HISTORY

Have you ever had or been treated for any of the following conditions or diseases?

	YES	NO
Angina Pectoris	O	O
Pacemaker	O	O
AIDS/ARC/HIV	O	O
Anemia	O	O
Venereal Disease	O	O
Arthritis	O	O
Asthma	O	O
Circulatory problems	O	O
Diabetes	O	O
Dizziness/fainting	O	O
Excessive bleeding	O	O
Glaucoma	O	O
Heart problems	O	O
High blood pressure	O	O
Kidney disease	O	O
Low blood pressure	O	O
Malignancies (cancer)	O	O
Liver disease	O	O
Nervous disorders	O	O
Bacterial endocarditis	O	O
Scarlet fever	O	O
Shortness of breath	O	O
Sinus problems	O	O
Stroke	O	O
Thyroid disorder	O	O
Tonsillitis	O	O
Tuberculosis	O	O
Ulcers	O	O
Joint replacements	O	O
Heart Murmur	O	O
Artificial heart valve	O	O
X-ray or cobalt treatments	O	O
Chemotherapy	O	O
Hepatitis	O	O
Epilepsy	O	O
Cortisone medicine	O	O
Rheumatic fever		
If yes, was heart affected?	O	O
Mitro-valve prolapse		
If yes, is there regurgitation?	O	O
Have you ever been premedicated before for dental treatment?	O	O

	YES	NO
Have you ever experienced a problem with local anesthesia?	O	O
Do you have pain/clicking when opening or closing your jaw?	O	O
Have you ever had TMJ treatment?	O	O
Do you have any discomfort in your mouth presently?	O	O
How often do you brush your teeth?	_____	
How often do you use dental floss?	_____	
When was the last time you had your teeth cleaned?	_____	
Have you ever been diagnosed as having periodontal disease?	O	O
Do you grind or clench your teeth?	O	O
Are you aware of any swelling or lump in your mouth?	O	O
Do your gums bleed when you brush your teeth?	O	O
Do you get frequent blisters on the lips or mouth?	O	O
Are you aware of any oral habits? Please indicate_____	O	O
How do you rate your dental health? (10 being the highest 1 2 3 4 5 6 7 8 9 10)	10	
Are you happy with the appearance of your smile?	O	O
What priority do you give your teeth? (10 being the highest 1 2 3 4 5 6 7 8 9 10)	10	

Please describe any current medical treatments, surgeries or any other medical or dental information that may affect your dental treatment.

_____

_____

The information given about my health history in this form is accurate to the best of my knowledge. I hereby give my consent to perform necessary diagnostic tests (including x-rays) and evaluation of my dental health.

_____

Signature of patient, parent or guardian Date

over

Medical review: I have reviewed this medical history and have added any changes since my last visit.

		Yes (◯) No (◯)
Signature	Date	Changes made

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