

PATIENT INFORMATION

CONFIDENTIAL

PATIENT # _____

(PLEASE PRINT)

DATE _____

NAME _____ BIRTHDATE _____ HOME PHONE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE/ZIP/PROV. P.C. _____

E-MAIL _____ CELL PHONE _____

CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED
PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER _____ WORK PHONE _____
STATE/ZIP/PROV. P.C. _____

BUSINESS ADDRESS _____ CITY _____
SPOUSE OR PARENT/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____
STATE/PROV. _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE/PROV. _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ FINANCIAL INSTITUTION _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/ZIP/PROV. P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/ZIP/PROV. P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/ZIP/PROV. P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/ZIP/PROV. P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

X
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

SIGNATURE

PATIENT NAME _____ TODAY'S DATE _____
 HOME ADDRESS _____ DATE OF BIRTH _____
 _____ HOME PHONE _____
 E-MAIL _____ CELL PHONE _____
 BUSINESS ADDRESS _____ BUSINESS PHONE _____
 _____ SS #/SIN _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO			
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	<input type="checkbox"/>	<input type="checkbox"/>	8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?	YES	NO
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	<input type="checkbox"/>	<input type="checkbox"/>	YES NO	YES NO	YES NO
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> LOCAL ANESTHETICS (E.G. NOVOCAINE)	<input type="checkbox"/> BARBITURATES	<input type="checkbox"/> ASPIRIN
4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> PENICILLIN OR OTHER ANTIBIOTICS	<input type="checkbox"/> SEDATIVES	<input type="checkbox"/> OTHER _____
5. DO YOU USE TOBACCO?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> SULFA DRUGS	<input type="checkbox"/> IODINE	
6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	<input type="checkbox"/>	<input type="checkbox"/>	9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)?	YES	NO
7. ARE YOU WEARING CONTACT LENSES?	<input type="checkbox"/>	<input type="checkbox"/>	10. WOMEN ONLY:	<input type="checkbox"/>	<input type="checkbox"/>
			A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>
			B) ARE YOU NURSING?	<input type="checkbox"/>	<input type="checkbox"/>
			C) ARE YOU TAKING BIRTH CONTROL PILLS?	<input type="checkbox"/>	<input type="checkbox"/>

II. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES NO	YES NO	YES NO
<input type="checkbox"/> <input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> <input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> <input type="checkbox"/> CHEST PAINS
<input type="checkbox"/> <input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> <input type="checkbox"/> CARDIAC PACEMAKER	<input type="checkbox"/> <input type="checkbox"/> EASILY WINDED
<input type="checkbox"/> <input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> <input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> <input type="checkbox"/> STROKE
<input type="checkbox"/> <input type="checkbox"/> SWOLLEN ANKLES	<input type="checkbox"/> <input type="checkbox"/> ANGINA	<input type="checkbox"/> <input type="checkbox"/> HAY FEVER / ALLERGIES
<input type="checkbox"/> <input type="checkbox"/> FAINTING / SEIZURES	<input type="checkbox"/> <input type="checkbox"/> FREQUENTLY TIRED	<input type="checkbox"/> <input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> <input type="checkbox"/> ASTHMA	<input type="checkbox"/> <input type="checkbox"/> ANEMIA	<input type="checkbox"/> <input type="checkbox"/> RADIATION THERAPY
<input type="checkbox"/> <input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> <input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> <input type="checkbox"/> GLAUCOMA
<input type="checkbox"/> <input type="checkbox"/> EPILEPSY / CONVULSIONS	<input type="checkbox"/> <input type="checkbox"/> CANCER	<input type="checkbox"/> <input type="checkbox"/> RECENT WEIGHT LOSS
<input type="checkbox"/> <input type="checkbox"/> LEUKEMIA	<input type="checkbox"/> <input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> <input type="checkbox"/> LIVER DISEASE
<input type="checkbox"/> <input type="checkbox"/> DIABETES	<input type="checkbox"/> <input type="checkbox"/> JOINT REPLACEMENT OR IMPLANT	<input type="checkbox"/> <input type="checkbox"/> HEART TROUBLE
<input type="checkbox"/> <input type="checkbox"/> KIDNEY DISEASES	<input type="checkbox"/> <input type="checkbox"/> HEPATITIS / JAUNDICE	<input type="checkbox"/> <input type="checkbox"/> RESPIRATORY PROBLEMS
<input type="checkbox"/> <input type="checkbox"/> AIDS OR HIV INFECTION	<input type="checkbox"/> <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE	<input type="checkbox"/> <input type="checkbox"/> OTHER _____
<input type="checkbox"/> <input type="checkbox"/> THYROID PROBLEM	<input type="checkbox"/> <input type="checkbox"/> STOMACH TROUBLES / ULCERS	

COMMENTS

SIGNATURE OF DENTIST _____ DATE _____

PATIENT DENTAL HISTORY

	YES	NO		YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	<input type="checkbox"/>	<input type="checkbox"/>	8. DO YOU HAVE FREQUENT HEADACHES?	<input type="checkbox"/>	<input type="checkbox"/>
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	<input type="checkbox"/>	<input type="checkbox"/>	9. DO YOU CLENCH OR GRIND YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	<input type="checkbox"/>	<input type="checkbox"/>	10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	<input type="checkbox"/>	<input type="checkbox"/>
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>	11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	<input type="checkbox"/>	<input type="checkbox"/>
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	<input type="checkbox"/>	<input type="checkbox"/>	12. HAVE YOU HAD ANY ORTHODONTIC WORK?	<input type="checkbox"/>	<input type="checkbox"/>
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	<input type="checkbox"/>	<input type="checkbox"/>	13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	<input type="checkbox"/>	<input type="checkbox"/>
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?			14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>
A) CLICKING?	<input type="checkbox"/>	<input type="checkbox"/>	15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	<input type="checkbox"/>	<input type="checkbox"/>
B) PAIN (JOINT, EAR, SIDE OF FACE)?	<input type="checkbox"/>	<input type="checkbox"/>			
C) DIFFICULTY IN OPENING OR CLOSING?	<input type="checkbox"/>	<input type="checkbox"/>			
D) DIFFICULTY IN CHEWING?	<input type="checkbox"/>	<input type="checkbox"/>			

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X _____ DATE _____
 PATIENT, PARENT OR GUARDIAN