Patient Information Form

Name _____
First Middle Last

Preferred Name _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home phone _____ Soc. Security # _____ Birth date _____

Work Phone _____ Email _____

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Sex: ❑ Male ❑ Female

Previous Dentist: _____ Preferred Pharmacy: _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Driver's license # _____ Birth Date _____ Soc. Security # _____

Employer _____ Work phone _____

Is this person currently a patient in our office? ❑ Yes ❑ No

Insurance Information

Name of Insured _____ Relationship to patient _____

Insured Birth date _____ Insured Soc. Security # _____

Policy/I.D.# _____ Insured Driver's License _____

Name of employer _____ Union or local # _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. Tel. # _____ Group #

_____

Ins. Co. Address _____ City _____ State _____ Zip _____

Authorization and Release

I authorize the dentist to release my information including the diagnosis and the records of any treatment extended to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist 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.

X _____ _____

Signature of patient (or parent, if minor) **Date**

Patient Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for taking your time to answer the following questions.

	YES	NO
1. Are you under medical treatment now?	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	❑	❑
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	❑	❑
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Phen-Fen/Redux?	❑	❑
5. Do you use tobacco?	❑	❑
6. Do you use controlled substances?	❑	❑
7. Are you wearing contact lenses?	❑	❑

8. Do you have or have you had any of the following?

	YES	NO		YES	NO		YES	NO
High Blood Pressure	❑	❑	Heart Murmur	❑	❑	Stroke	❑	❑
Heart Attack	❑	❑	Angina	❑	❑	Hay Fever / Allergies	❑	❑
Rheumatic Fever	❑	❑	Frequently Tired	❑	❑	Tuberculosis	❑	❑
Swollen Ankles	❑	❑	Anemia	❑	❑	Radiation Therapy	❑	❑
Fainting / Seizures	❑	❑	Emphysema	❑	❑	Glaucoma	❑	❑
Epilepsy / Convulsions	❑	❑	Cancer	❑	❑	Recent Weight Loss	❑	❑
Leukemia	❑	❑	Arthritis	❑	❑	Liver Disease	❑	❑
Diabetes	❑	❑	Joint Replacement or Implant	❑	❑	Heart Trouble	❑	❑
Kidney Diseases	❑	❑	Hepatitis / Jaundice	❑	❑	Respiratory Problems	❑	❑
AIDS or HIV Infection	❑	❑	Sexually Transmitted Disease	❑	❑	Mitral Valve Prolapse	❑	❑
Thyroid Problem	❑	❑	Stomach Troubles / Ulcers	❑	❑	Other _____		
Heart Disease	❑	❑	Chest Pains	❑	❑			
Cardiac Pacemaker	❑	❑	Easily Winded	❑	❑			

9. Are you allergic to or have you had any reactions to the following:

	YES	NO		YES	NO
Local Anesthetics (e.g. novocain)	❑	❑	Iodine	❑	❑
Penicillin or other Antibiotics	❑	❑	Aspirin	❑	❑
Sulfa Drugs	❑	❑	Any Metals (e.g. nickel, mercury, etc.)	❑	❑
Barbiturates	❑	❑	Latex Rubber	❑	❑
Sedatives	❑	❑	Other _____	❑	❑

10. Women Only:

	YES	NO
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
a) Are you taking oral contraceptives?	❑	❑

Patient Dental History

Name of Previous Dentist _____ Date of Last Exam _____

Previous Dentist's Location _____ Date of Last Cleaning _____

	YES	NO
1. Do your gums bleed while brushing or flossing?	❑	❑
2. Are your teeth sensitive to hot or cold liquids/foods?	❑	❑
3. Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑
4. Do you feel pain to any of your teeth?	❑	❑
5. Do you have any sores or lumps in or near your mouth?	❑	❑
6. Have you had any head, neck or jaw injuries?	❑	❑
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	❑	❑
Pain (joint, ear, side of face)	❑	❑
Difficulty in opening or closing	❑	❑
Difficulty in chewing	❑	❑
8. Do you have frequent headaches?	❑	❑
9. Do you clench or grind your teeth?	❑	❑
10. Do you bite your lips or cheeks frequently?	❑	❑
11. Have you ever had any difficult extractions in the past?	❑	❑
12. Have you ever had any prolonged bleeding following extractions?	❑	❑
13. Have you had any orthodontic treatment?	❑	❑
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	❑	❑
16. Do you like your smile?	❑	❑

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **Date** _____

Doctor's Comments

_____

_____

_____

Signature _____ Date _____