CONFIDENTIAL PATIENT INFORMATION

(PLEASE PRINT)

Patient Name_____ Birthdate_____

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

Home Address_____ Home Phone _____

_____ Cell Phone_____

Social Security Number_____Email:_____

Patient's Employer _____ Work Phone_____

Business Address_____City_____State_____ Zip_____

Spouse or Parent's Name_____Employer_____Work Phone_____

Whom may we thank for referring you?_____

Person to contact in case of emergency_____Phone_____

Responsible Party

Name of Person Responsible for this Account_____Relationship to Patient_____

Address_____City_____State_____Zip_____

Home Phone_____Birthdate_____Social Security Number_____

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

Insurance Information

Name of Insured_____Relationship to patient_____

Home Phone_____Birthdate_____Social Security Number_____

Insurance Company_____Employer_____

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of Insured_____Relationship to patient_____

Home Phone_____Birthdate_____Social Security Number_____

Insurance Company_____Employer_____

I certify that the above information is correct to the best of my knowledge. I realize that the insurance is not a guarantee of payment and is between me and my insurance company. I realize that I am responsible for the balance on this account.

Signature _____ **Date**_____

Patient, Parent or Guardian

Today's Date_____

Patient Name_____

Birthdate_____

Patient Medical History

Physician_____ Office Phone_____ Date of Last Exam_____

1. Are you under medical treatment now? ☐Yes ☐No

2. Have you ever been hospitalized for any surgical operation or serious illness? ☐Yes ☐No

3. Are you taking any medication(s) including non-prescription medicine? ☐Yes ☐No
If yes, what medication(s) are you taking?_____
_____

4. Do you use tobacco? ☐Yes ☐No

5. Do you use alcohol? ☐Yes ☐No

6, Do you use cocaine or other drugs? ☐Yes ☐No

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

☐Yes ☐No High blood pressure	☐Yes ☐No Heart Disease	☐Yes ☐No Chest Pains
☐Yes ☐No Heart attack	☐Yes ☐No Cardiac pacemaker	☐Yes ☐No Easily winded
☐Yes ☐No Rheumatic fever	☐Yes ☐No Heart Murmur	☐Yes ☐No Stroke
☐Yes ☐No Swollen ankles	☐Yes ☐No Angina	☐Yes ☐No Hay fever/allergies
☐Yes ☐No Fainting/seizures	☐Yes ☐No Frequently tired	☐Yes ☐No Tuberculosis
☐Yes ☐No Asthma	☐Yes ☐No Anemia	☐Yes ☐No Radiation Therapy
☐Yes ☐No Low blood pressure	☐Yes ☐No Emphysema	☐Yes ☐No Glaucoma
☐Yes ☐No Epilepsy/convulsions	☐Yes ☐No Cancer	☐Yes ☐No Recent weight loss
☐Yes ☐No Leukemia	☐Yes ☐No Arthritis	☐Yes ☐No Liver Disease
☐Yes ☐No Diabetes	☐Yes ☐No Heart trouble	☐Yes ☐No Joint replacement or implant
☐Yes ☐No Kidney Diseases	☐Yes ☐No Hepatitis/jaundice	☐Yes ☐No Sexually transmitted disease
☐Yes ☐No Aids or HIV infection	☐Yes ☐No Thyroid problem	☐Yes ☐No Other_____
☐Yes ☐No Stomach troubles/ulcers	☐Yes ☐No Respiratory problems	_____

8. Are you wearing contact lenses? ☐Yes ☐No

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

☐Yes ☐No Local Anesthetics (eg. Novocaine)	☐Yes ☐No Barbituarates
☐Yes ☐No Aspirin	☐Yes ☐No Sedatives
☐Yes ☐No Penicillin or other Antibiotics	☐Yes ☐No Sulfa Drugs
☐Yes ☐No Iodine	☐Yes ☐No Other_____
	_____

10. Women only:
Are you pregnant or think you may be pregnant? ☐Yes ☐No
Are you nursing? ☐Yes ☐No
Are you taking birth control pills? ☐Yes ☐No

Patient Dental History

1. Do your gums bleed while brushing or flossing? ☐Yes ☐No

2. Are your teeth sensitive to hot/cold liquids/foods? ☐Yes ☐No

3. Are your teeth sensitive to sweet/sour liquids/foods? ☐Yes ☐No

4. Do you feel pain to any of your teeth? ☐Yes ☐No

5. Do you have any sores or lumps in or near your mouth? ☐Yes ☐No

6. Have you had any head, neck or jaw injuries? ☐Yes ☐No

7. Have you ever experienced any of the following problems in your jaw?
A. Clicking? ☐Yes ☐No
B. Pain (joint, ear, side of face)? ☐Yes ☐No
C. Difficult in opening or closing? ☐Yes ☐No
D. Difficulty in chewing? ☐Yes ☐No

8. Do you have frequent headaches? ☐Yes ☐No

9. Do you clench or grind your teeth? ☐Yes ☐No

10. Do you bite your lips or cheeks frequently? ☐Yes ☐No

11. Have you ever had any difficult extractions in the past? ☐Yes ☐No

12. Have you had any orthodontic work? ☐Yes ☐No

13. Have you ever had prolonged bleeding following extractions? ☐Yes ☐No

14. Have you ever had instruction on the correct method of brushing your teeth? ☐Yes ☐No

15. Have you ever had instructions on the care of your gums? ☐Yes ☐No

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.

Signature _____ **Date**_____

Patient, Parent or Guardian