

PATIENT INFORMATION

Date _____

Name: Last _____ First _____ MI _____

Address : Street _____ City _____ State ___ Zip _____

Home Phone _____ Cell Phone _____

Business Phone _____ E-mail Address _____

Birth Date _____ Social Security # _____

Business Name / Address _____

Hobbies and Interests (optional) _____

Whom may we thank for referring you to our office? Please check all that apply:

Friend/Family/Doctor _____ Internet _____ Yellow Pages _____

FAMILY INFORMATION

HUSBAND (Father if a minor)	WIFE (Mother if a minor)
Name _____	Name _____
Address _____	Address _____
City/State _____	City/State _____
Telephone _____	Telephone _____
Birth Date/SSN _____	Birth Date/ SSN _____
Employer _____	Employer _____

PERSON RESPONSIBLE FOR ACCOUNT: Please circle one: Patient/Father/Husband/Mother/Wife/Guardian

PERSON TO CONTACT IN CASE	Name _____
OF EMERGENCY	Home Phone _____ Cell _____

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary, with my permission (patient) for proper dental care.

I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another doctor.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claim for insurance benefits.

If you would like our assistance in obtaining your insurance benefits, please furnish your insurance card or information.

I attest to the accuracy of the information provided on this page.

SIGNATURE OF RESPONSIBLE PARTY _____ **DATE** _____

MEDICAL HISTORY

Patient Name: _____ Date: _____

Presently under a physicians care? Yes /No Date of last physical exam: _____

Physician's Name: _____ Phone: _____

DO YOU HAVE ANY OF THE FOLLOWING?

Please indicate those which apply by **circling**, and those which do not apply by a **slash**.

Hospitalization/Surgery

Hepatitis (Yourself/Family)

Rheumatic Fever

Infectious Diseases (Yourself/Family)

Heart Murmur

Systemic Lupus Erythematosus

Mitral Valve Prolapse

Ulcers

Prosthetic (artificial) Heart Valve/Artificial Joints

Arthritis

Bleeding Tendency

Cancer

High Blood Pressure (Yourself/Family)

Leukemia/Multiple Myeloma/Lymphoma

Breathing Problems/Asthma

Seizures/Stroke

Anemia

Psychiatric Care

Diabetes (Yourself/Family)

Sinus Problems

Blood thinners/Coumadin/Aspirin

Thyroid Problems

History of Phen-Fen (Ionamn-phentermine, Pondimin-fenfluramine)

Use of Tobacco

Taking Medications/Drugs/ Natural Remedies:

Use of Alcohol

Please List Medications or Furnish a Copy:

Pregnant/Breast Feeding

Last Menstrual Period Date _____

Allergies to Drugs or Medications: _____

Do you have problems or conditions not listed above? Yes _____ No _____

Do you wish to discuss anything with the doctor in private? Yes _____ No _____

I understand the importance of a truthful health history and I realize that incomplete information may have an adverse effect on my health.

Signature of Patient or Guardian _____ Date _____

Signature of Witness _____ Date _____

DENTAL HISTORY

Patient name: _____ Date: _____

Date of last dental examination: _____ Date of last dental cleaning: _____

How many times a year do you have you teeth cleaned? (Circle one) 1 2 3 4

How many times a year has it been recommended by your previous dentist that you have your teeth cleaned? (Circle one) 1 2 3 4

How many times do you brush daily? (Circle one) 1 2 3 4

How often do you floss? (Circle one) Daily Weekly Sometimes Never

DO YOU HAVE ANY OF THE FOLLOWING?

Please indicate those that **apply to you by circling**, indicate those that **do not apply to you by slashing** through the item.

Bleeding Gums

Toothache

Receding Gums

Clench or Grind Your Teeth

Gag Easily

Difficulty Chewing Food

Bad Taste/Odor in Mouth

Mouth Sores/Herpes

Previous Gum (Periodontal) Treatment

Jaw muscles tired at the end of the day/morning

Teeth Loose

Upon opening your mouth, clicking/grating noise?

Do you feel any limitation when opening your mouth? Yes _____ No _____

Ever had trauma to the face/head? Yes _____ No _____

Do you wear full/partial dentures? Upper _____ Yes _____ No _____ How long? _____

Lower _____ Yes _____ No _____ How Long? _____

Do you have problems with your full/partial dentures? Yes _____ No _____

Would you like to change the appearance of your teeth? Yes _____ No _____

What is the purpose of today's visit? _____

Signature of Patient or Guardian _____ Date _____

Signature of Witness _____ Date _____