PATIENT INFORMATION

CONFIDENTIAL

PATIENT # ______________________

DATE ______________________

PLEASE FILL IN ALL APPLICABLE FIELDS

NAME ______________________ BIRTH DATE ______________ HOME PHONE ______________

ADDRESS ______________________ CITY ______________ STATE ________ ZIP ________

CHECK APPROPRIATE BOX: ❑ MINOR ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑ SEPARATED

PATIENT'S OR PARENT'S EMPLOYER ______________________ WORK PHONE ______________

BUSINESS ADDRESS ______________________ CITY ______________ STATE ________ ZIP ________

SPOUSE OR PARENT'S NAME ______________________ EMPLOYER ______________ WORK PHONE ______________

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE ______________________ CITY ______________ STATE ____

PERSON TO CONTACT IN CASE OF AN EMERGENCY ______________________ PHONE ______________

WHOM MAY WE THANK FOR REFERRING YOU? ______________________

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ______________________ RELATIONSHIP TO PATIENT ______________

ADDRESS ______________________ HOME PHONE ______________

SOCIAL SECURITY NUMBER ______________________

EMPLOYER ______________________ WORK PHONE ______________

ADDRESS ______________________

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

INSURANCE INFORMATION

NAME OF INSURED ______________________ RELATIONSHIP TO PATIENT ______________

BIRTH DATE ______________ SOCIAL SECURITY NUMBER ______________ DATE EMPLOYED ______________

NAME OF EMPLOYER ______________________ WORK PHONE ______________

ADDRESS OF EMPLOYER ______________________ CITY ______________ STATE ________ ZIP ________

INSURANCE COMPANY ______________________ GROUP # ______________ UNION/LOCAL # ______________

INS. CO. ADDRESS ______________________ CITY ______________ STATE ________ ZIP ________

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 ______________

BIRTH DATE ______________ SOCIAL SECURITY NUMBER ______________ DATE EMPLOYED ______________

NAME OF EMPLOYER ______________________ WORK PHONE ______________

ADDRESS OF EMPLOYER ______________________ CITY ______________ STATE ________ ZIP ________

INSURANCE COMPANY ______________________ GROUP # ______________ UNION/LOCAL # ______________

INS. CO. ADDRESS ______________________ CITY ______________ STATE ________ ZIP ________

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

____

X SIGNATURE OF PATIENT OR PARENT, IF MINOR

PATIENT NAME ______________________ TODAY'S DATE ______________

HOME ADDRESS ______________________ DATE OF BIRTH ______________

CITY ____________ STATE ________ ZIP ____________ HOME PHONE ______________

BUSINESS ADDRESS ______________________ BUSINESS PHONE ______________

CITY ____________ STATE ________ ZIP ____________ SOC. SEC. NO. ______________

PATIENT NAME

PATIENT MEDICAL HISTORY

PHYSICIAN ______________ OFFICE PHONE ______________ DATE OF LAST EXAM ______________

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW	❑	❑
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION FOR SERIOUS ILLNESS?	❑	❑
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? IF YES, WHAT MEDICATION(S) ARE YOU TAKING?	❑	❑
4. DO YOU USE TOBACCO?	❑	❑
5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	❑	❑
6. ARE YOU WEARING CONTACT LENSES?	❑	❑

7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS? IF YES, PLEASE SPECIFY.

8. WHEN WAS YOUR LAST COMPLETE PHYSICAL?

9. WOMEN ONLY:	YES	NO
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT(?)	❑	❑
B) ARE YOU NURSING?	❑	❑
C) ARE YOU TAKING BIRTH CONTROL PILLS	❑	❑

10. PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

- ❑ HIGH BLOOD PRESSURE
- ❑ HEART ATTACK
- ❑ RHEUMATIC FEVER
- ❑ SWOLLEN ANKLES
- ❑ FAINTING/SEIZURES
- ❑ ASTHMA
- ❑ LOW BLOOD PRESSURE
- ❑ EPILEPSY/CONVULSIONS
- ❑ LEUKEMIA
- ❑ DIABETES
- ❑ HEART DISEASE
- ❑ CARDIAC PACE MAKER
- ❑ HEART MURMUR
- ❑ ANGINA
- ❑ FREQUENTLY TIRED
- ❑ ANEMIA
- ❑ EMPHYSEMA
- ❑ CANCER
- ❑ ARTHRITIS
- ❑ JOINT REPLACEMENT OR IMPLANT
- ❑ CHEST PAINS
- ❑ EASILY WINDED
- ❑ STROKE
- ❑ HAY FEVER/ALLERGIES
- ❑ TUBERCULOSIS
- ❑ RADIATION THERAPY
- ❑ GLAUCOMA
- ❑ RECENT WEIGHT LOSS
- ❑ LIVER DISEASE
- ❑ HEART TROUBLE
- ❑ KIDNEY DISEASES
- ❑ AIDS/HIV INFECTION
- ❑ THYROID PROBLEM
- ❑ HEPATITIS/JAUNDICE
- ❑ SEXUALLY TRANSMITTED DISEASE
- ❑ STOMACH TROUBLE/ULCERS
- ❑ RESPIRATORY PROBLEMS
- ❑ OTHER

COMMENTS

PATIENT DENTAL HISTORY

PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? ❑
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOOD? ❑
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUID/FOODS? ❑
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? ❑
5. DO YOU HAVE ANY SORES OR LUMPS IN YOUR EAR OR MOUTH? ❑
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? ❑
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?
   A) CLICKING? ❑
   B) PAIN (JOINT, EAR, SIDE OF FACE)? ❑
   C) DIFFICULTY IN OPENING OR CLOSING)? ❑
   D) 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 DIFFICULTY EXTRACTIONS IN THE PAST?
12. HAVE YOU HAD ANY ORTHODONTIC WORK? ❑
13. HAVE YOU HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS? ❑
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? ❑
15. HAVE YOU EVER HAD INSTRUCTION ON THE CARE OF YOUR GUMS? ❑

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 PATIENT, PARENT OR GUARDIAN ______________________ DATE