

# PATIENT INFORMATION

**Please Print Legibly**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Sex M / F  
Last First Middle

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS # \_\_\_\_-\_\_\_\_-\_\_\_\_ Please Circle: Single / Married / Widowed / Divorced

Address: \_\_\_\_\_  
Street City State Zip Code

Home Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell (\_\_\_\_)\_\_\_\_-\_\_\_\_

E-mail Address: \_\_\_\_\_ Beeper/Pager (\_\_\_\_)\_\_\_\_-\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Work Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## HEALTH HISTORY

Physician: \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Pharmacy Name & Phone: \_\_\_\_\_

Please mark "Yes" or "No" to indicate if you have ever had any of the following:

Cardiovascular	Neurological	Musculoskeletal	
Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No	Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis / Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No	
Angina <input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness, Fainting <input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone / Steroid Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	
Arteriosclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy / Seizure <input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Replacement (knee, hip, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Atrial Fibrillation <input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Gastrointestinal</b>	
Circulation Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea, persistent <input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart Attack Date: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	Vision / Hearing Impairment <input type="checkbox"/> Yes <input type="checkbox"/> No	Digestive Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart Defect <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Respiratory</b>		
Heart Murmur / Leaky Valve <input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Hiatal Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No	
High or Low Blood Pressure (circle) <input type="checkbox"/> Yes <input type="checkbox"/> No	Cough, persistent or bloody <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mitral Valve Prolapse / MVP <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis, Type: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pacemaker / Defibrillator <input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer / Hyperacidity <input type="checkbox"/> Yes <input type="checkbox"/> No	
Rheumatic or Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Infection <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Other</b>	
Stroke Date: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Infectious Diseases</b>		
Swelling of Feet or Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No	HIV / AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No	Autoimmune / Immune Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other <input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Glands -neck <input type="checkbox"/> Yes <input type="checkbox"/> No	Chemo - Radiation <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Circulatory / Hematological</b>		Cancer Type: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	
Abnormal Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	
Leukemia / Lymphoma <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Endocrinological</b>		
Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes Type: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, Unexplained <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Thyroid: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth Control Pills: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Pregnant Due: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please list any other medical concerns/conditions we should know about: \_\_\_\_\_

Have you ever taken bisphosphonates? (Bone Sparing Drugs - i.e. Fosamax, Actonel, Reclast, Boniva): Y / N

Have you ever been told you need to premedicate or take antibiotics prior to a dental procedure? Y / N

If so, for what condition?

Do you currently take aspirin or medications that contain aspirin frequently or on a daily basis? Y / N

MEDICATIONS	ALLERGIES	SURGERY
List all medications you are currently taking:	Circle Yes or No	List ALL past surgery, major and minor please:
Aspirin	Yes No	
Barbiturates	Yes No	
Codeine/Other Narcotics	Yes No	
Iodine	Yes No	
Latex	Yes No	
Local Anesthesia	Yes No	
Penicillin	Yes No	
Sulfa	Yes No	
Other Antibiotics _____	Yes No	
Other: _____		
Other: _____		
		Tobacco Use: (circle all that apply)
		Cigarettes Cigars Pipe Chew/Dip
		How often?

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

# RESPONSIBLE PARTY INFORMATION

Please Print Legibly

Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
(Last) (First) (Middle)  
Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)  
Phone: (\_\_\_\_) \_\_\_\_\_  
Signature of Responsible Party: \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

Name of Insured: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Insured's Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN#: \_\_\_\_-\_\_\_\_-\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
Employer: \_\_\_\_\_  
(Name) (Address)  
Insurance Company: \_\_\_\_\_ Group# \_\_\_\_\_ ID Number \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
(City) (ST) (Zip)

### Do You Have Additional Insurance? Yes / No If yes, please complete the following:

Name of Insured: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Insured's Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN#: \_\_\_\_-\_\_\_\_-\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
Employer: \_\_\_\_\_  
(Name) (Address)  
Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ ID Number: \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_  
(City) (ST) (Zip)

## ASSIGNMENT & RELEASE

I, the undersigned, certify that I have insurance coverage as stated above, and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_ Former Dentist: \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ Date of last dental X-rays: \_\_\_\_\_

## DENTAL HISTORY

Please mark "Yes" or "No" to indicate if you have ever had any of the following:

Bad Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food Collection Between Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign Objects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain Around Ear	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on Lips or Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning Sensation/Tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gums Swollen or Tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to Cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chewing on One Side	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain or Tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to Heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cigarette, Pipe or Cigar Use	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or Cheek Biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to Sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking or Popping Jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose Teeth or Broken Fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity When Biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or Growths in Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fingernail Biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth Pain, Brushing	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____	
Other _____				How often do you brush? _____	