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 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 Fen-Phen/Redux?		
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?		
6. Do you use tobacco?		
7. Do you use controlled substances?		

	Yes	No
9. Are you wearing contact lenses?		
10. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)		
Penicillin or any other Antibiotics		
Sulfa Drugs		
Barbiturates		
Sedatives		
Iodine		
Aspirin		
Any Metals (e.g. nickel, mercury, etc.)		
Latex Rubber		
Other (please list) _____		
11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?		
12. Women Only:		
a) Are you pregnant or think you may be pregnant?		
b) Are you nursing?		
c) Are you taking oral contraceptives?		

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

	Yes	No		Yes	No		Yes	No
High Blood Pressure			Heart Disease			Chest Pains		
Heart Attack			Cardiac Pacemaker			Easily Winded		
Rheumatic Fever			Heart Murmur			Stroke		
Swollen Ankles			Angina			Hay Fever / Allergies		
Fainting / Seizures			Frequently Tired			Tuberculosis		
Asthma			Anemia			Radiation Therapy		
Low Blood Pressure			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 _____		
Acid Reflux			Osteoporosis					

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	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		

	Yes	No
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?		
14. Do you wear dentures or partials?		
If yes, date of placement _____		
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

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. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group 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/guardian if minor) Date

Doctor's Comments _____

_____ Signature _____ Date _____

Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____

SS#/SIN _____

Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

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

If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian'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 _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License# _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

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

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.
☐ Discover ☐ AMEX

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group# _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

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 _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group# _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please