

WELCOME TO OUR OFFICE

Please PRINT the following information, which is important for our records and your health. *All information is strictly confidential.*

Patient's Full Name _____ Birth Date _____ Age _____

Single Married Separated Divorced Widowed Patient's Social Security # _____

Home Address _____ City _____ State _____ Zip _____

Business Address _____ City _____ State _____ Zip _____

Employed By _____ Occupation _____

Telephone: Residence _____ Business _____ Ext. _____ Cell _____

Email: _____

Spouse's or Parent's Full Name _____ Employed By _____

Occupation _____ Telephone _____

Dental Insurance Company _____ Insured's Social Security # _____

Insured's Date of Birth _____

Who Will Pay This Account? _____ Address _____

Referred By _____ Former Dentist _____ Date Last Seen _____

Name of Physician _____

Purpose of Visit _____

MEDICAL HISTORY

1. Are you having pain or discomfort at this time? YES NO
 2. Do you feel very nervous about having dental treatment? YES NO
 3. Have you ever had an unpleasant experience in a dental office? YES NO
 4. Have you been a patient in the hospital during the past five years? YES NO
 5. Have you been under the care of a medical doctor during the past two years? YES NO
 6. Are you now taking any medication or drugs? YES NO
- If so, please list _____
7. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? YES NO
 8. Have you ever had any excessive bleeding requiring special treatment? YES NO
 9. Circle any of the following which you have had or have at present? YES NO
- | | | | |
|--------------------------|--------------------|---------------------------------|---------------------------------------|
| Heart Failure | Anemia | X-Ray or Cobalt Treatment | Yellow Jaundice |
| Heart Disease or Attack | Stroke | Chemotherapy (Cancer, Leukemia) | Blood Transfusion |
| Angina Pectoris | Kidney Trouble | Arthritis | Drug Addiction |
| High Blood Pressure | Ulcers | Rheumatism | Hemophilia |
| Heart Murmur | Emphysema | Cortisone Medicine | Veneret Disease (Syphilis, Gonorrhea) |
| Rheumatic Fever | Cough | Glaucoma | Cold Sores/Herpes |
| Congenital Heart Lesions | Tuberculosis (TB) | Hiatal Hernia | Shortness of Breath |
| Scarlet Fever | Asthma | AIDS | Epilepsy or Seizures |
| Artificial Heart Valve | Hay Fever | Hepatitis A (Infectious) | Fainting or Dizzy Spells |
| Heart Pacemaker | Sinus Trouble | Hepatitis B (Serum) | Nervousness |
| Heart Surgery | Allergies or Hives | Hepatitis C | Psychiatric Treatment |
| Artificial Joint | Diabetes | Liver Disease | Sickle Cell Disease |
| | Thyroid Disease | HIV | Bruise Easily |
10. Do you ankles swell during the day? YES NO
 - Do you use more than two pillows to sleep? YES NO
 - Do you ever wake up from sleep short of breath? YES NO
 11. Has your medical doctor ever said you have a cancer or tumor? YES NO
 12. Do you have any disease, condition, or problem not listed? YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Date _____

Signature of Patient, Parent or Guardian

Dentist's Signature

(Turn Over)

DENTAL HEALTH INFORMATION

How often do you brush your teeth? _____

What texture brush do you use? SOFT MEDIUM HARD NYLON NATURAL

How often do you floss? _____

Do you use fluoride rinse or gel? YES NO

Do your gums bleed while brushing? YES NO

Do your gums bleed while flossing? YES NO

Do you avoid brushing any part of your mouth because of pain? YES NO

If yes, what part? _____

Are your teeth sensitive?..... YES NO

To what? _____

Have your teeth ever been replaced by..... (1) fixed bridge (2) removable partial (3) denture

Do you clench or grind your jaws while sleeping or during the day? YES NO

Do your jaws ever feel tired or painful? YES NO

Have you had your teeth straightened? YES NO When? _____

Have you ever had a gum treatment? YES NO When? _____

Are you interested in a preventive or plaque control program? YES NO

Do you desire gas sedation for your dental treatment? YES NO

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? YES NO

Are you on a special diet?..... YES NO

WOMAN: Are you pregnant now? YES NO Do you anticipate being pregnant? YES NO

Please add anything you feel is important: _____

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED (PATIENT OR PARENT OF MINOR)

DATE

SIGNED (INSURED PERSON)

DATE

MEDICAL HISTORY UPDATE

There has been no change in my health or medications since the last signed medical history or medical history update.

Date	Signature of Patient, Parent or Guardian	Dentist's Signature
Date	Signature of Patient, Parent or Guardian	Dentist's Signature
Date	Signature of Patient, Parent or Guardian	Dentist's Signature
Date	Signature of Patient, Parent or Guardian	Dentist's Signature
Date	Signature of Patient, Parent or Guardian	Dentist's Signature
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PLEASE NOTE: Filing insurance claims is a service provided without charge, but in no way relieves you of responsibility for your bill. If you would like our office to submit a claim to your insurance company, please present a signed insurance form with patient information completed for each visit. Arrangements must be made for balance or accounts after 60 days.