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	Venereal 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.

_____ _____
SIGNED (PATIENT, OR PARENT OF MINOR) DATE

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

_____ _____
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*
Date	*Signature of Patient, Parent or Guardian*	*Dentist's Signature*

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.*