## patient information

last name of patient | first name | middle | cell phone ( ) | home telephone ( ) | email

residence | city | State | ZIP | ☐ single ☐ married ☐ divorced ☐ widowed | sex ☐ MALE ☐ FEMALE

social security number | driver license no. | birthdate | age | occupation

responsible party or spouse | relationship to patient | social security number | driver license no.

address | city | ZIP | telephone ( )

employer | address | city | ZIP | work telephone ( )

## insurance information

insured name | social security no. | birth date | relationship to patient

employer | address | city | ZIP | telephone ( )

dental insurance carrier | date employed | group number

medical insurance carrier | date employed | group number

are you covered by another plan? yes ☐ no ☐ | social security no. | birth date | group number

if so, name of carrier:

## medical history of patient

| | YES | NO |
|---|---|---|
| Do you have any general health problems? | ☐ | ☐ |
| If so, please specify: _____ | | |
| Have you had surgery? | ☐ | ☐ |
| If so, please specify: _____ | | |
| Are you currently under a physician's care? | ☐ | ☐ |
| Reason: _____ | | |

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Any heart problems | ☐ | ☐ | Malignancies | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | Measles | ☐ | ☐ |
| Low blood pressure | ☐ | ☐ | Mumps | ☐ | ☐ |
| Circulatory problems | ☐ | ☐ | Psychiatric care | ☐ | ☐ |
| Nervous problems | ☐ | ☐ | Rheumatic fever | ☐ | ☐ |
| Radiation treatments | ☐ | ☐ | Scarlet fever | ☐ | ☐ |
| Excessive bleeding | ☐ | ☐ | Sinus problems | ☐ | ☐ |
| AIDS (HIV) | ☐ | ☐ | Stroke | ☐ | ☐ |
| Allergies to anesthetics | ☐ | ☐ | Typhoid Fever | ☐ | ☐ |
| Allergies to medicines or drugs | ☐ | ☐ | Tonsillitis | ☐ | ☐ |
| Allergies to: _____ | | | Tuberculosis | ☐ | ☐ |
| Anemia | ☐ | ☐ | Ulcer | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Venereal Disease | ☐ | ☐ |
| Asthma | ☐ | ☐ | Other | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Are you pregnant? | ☐ | ☐ |
| Hepatitis | ☐ | ☐ | Blood Pressure: | ☐ | ☐ |
| Herpes | ☐ | ☐ | S____ / ____ D ____ / ____ | | |

## dental history of patient

What is your present dental problem? _____

When was your last visit to the dentist? _____

Why did you leave the Dental Office? _____

Are your teeth sensitive to

heat: ☐ sweets: ☐

cold: ☐ biting pressure: ☐

| | YES | NO |
|---|---|---|
| Does food catch between your teeth? | ☐ | ☐ |
| Do your gums bleed when brushing? | ☐ | ☐ |
| Have you noticed any gum swelling around any teeth? | ☐ | ☐ |
| Do you ever avoid any part of the mouth while brushing? | ☐ | ☐ |
| Are you satisfied with your teeth and their appearance? | ☐ | ☐ |
| Are you deeply concerned about the finances required to return your mouth to excellent dental health? | ☐ | ☐ |
| Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? | ☐ | ☐ |
| Do you want to learn to control dental and gum disease? | ☐ | ☐ |
| Do you have bad breath or odor in your mouth? | ☐ | ☐ |
| Do you smoke? | ☐ | ☐ |
| Have you ever had any teeth removed? | ☐ | ☐ |
| How long have these teeth been missing? _____ | | |
| Have you had an allergic reaction to local anesthesia? | ☐ | ☐ |

Who referred you to our office? _____

| | YES | NO |
|---|---|---|
| Permission is granted to perform necessary treatment for minor patient | ☐ | ☐ |

Person financially responsible (if other than patient) _____

How were your previous dental visits? _____

I, the undersigned shall be responsible for the payment of charges incurred for all services rendered.

I, the undersigned shall be responsible for the payment of all charges in excess of existing insurance coverage.

Date: _____ Signature of Patient, Parent, or Guardian : _____

# HEALTH HISTORY

| | Yes | No |
|---|---|---|
| Do You Have Allergy to Latex? | ☐ | ☐ |
| Have You Taken Fen-Phen Redux? | ☐ | ☐ |
| Are You Taking Any Medication? | ☐ | ☐ |

Please List: _____

_____

Name of Physician: _____

Phone Number of of Physician: _____

**Sign:** _____ **Date:** _____

---

**RECALL REVIEW:** _____

1. Patient's Signature _____ Date: _____
2. Patient's Signature _____ Date: _____
3. Patient's Signature _____ Date: _____

---

**For Office Use Only**

1. Doctor's Review _____ Date: _____
2. Doctor's Review _____ Date: _____
3. Doctor's Review _____ Date: _____