

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. **Please print.** All information will be confidential.

Date _____ Patient Name _____ Patient # _____
SSN _____ Male Female Birthdate _____ Home phone _____
Address _____ City _____ State _____ Zip _____
Check appropriate box: Minor Single Married Divorced Widowed Separated
Patient's or parent's employer _____ Work phone _____
Business address _____ City _____ State _____ Zip _____
Spouse or parent's name _____ Employer _____ Work phone _____
If patient is a student, name of school/college _____ City _____ State _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____
In case of a medical emergency, if the patient is of school age 15+, it is all right to treat in my absence.

X _____
Parent or guardian signature _____ Date _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____
Address _____ Home phone _____
Driver's license # _____ Birthdate _____ Financial institution _____
Employer _____ Work phone _____
Is this person currently a patient at our office? Yes No

Insurance Information

Name of insured _____ Relationship to patient _____
Birthdate _____ Social Security Number _____ Date employed _____
Name of employer _____ Work phone _____
Address of employer _____ City _____ State _____ Zip _____
Insurance company _____ Group # _____ Union or local # _____
Ins. Co. address _____ City _____ State _____ Zip _____
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 _____ Social Security Number _____ Date employed _____
Name of employer _____ Work phone _____
Address of employer _____ City _____ State _____ Zip _____
Insurance company _____ Group # _____ Union or local # _____
Ins. Co. address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____
Signature of patient or parent if minor _____ Date _____

PATIENT NAME _____	TODAY'S DATE _____
HOME ADDRESS _____	DATE OF BIRTH _____
E-MAIL _____	HOME PHONE _____
BUSINESS NAME _____	CELL PHONE _____
	BUSINESS PHONE _____
	SS #/SIN _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____	OFFICE PHONE _____	DATE OF LAST EXAM _____
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<p>1. ARE YOU UNDER MEDICAL TREATMENT NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____</p> <p>4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. DO YOU USE TOBACCO? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>7. ARE YOU WEARING CONTACT LENSES? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?</p> <table style="width: 100%;"> <tr> <td style="width: 33%;">YES NO</td> <td style="width: 33%;">YES NO</td> <td style="width: 33%;">YES NO</td> </tr> <tr> <td><input type="checkbox"/> LOCAL ANESTHETICS (EG. NOVOCAINE)</td> <td><input type="checkbox"/> BARBITURATES</td> <td><input type="checkbox"/> ASPIRIN</td> </tr> <tr> <td><input type="checkbox"/> PENICILLIN OR OTHER ANTIBIOTICS</td> <td><input type="checkbox"/> SEDATIVES</td> <td><input type="checkbox"/> OTHER _____</td> </tr> <tr> <td><input type="checkbox"/> SULFA DRUGS</td> <td><input type="checkbox"/> IODINE</td> <td></td> </tr> </table> <p>9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>10. WOMEN ONLY:</p> <p>A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>B) ARE YOU NURSING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>C) ARE YOU TAKING BIRTH CONTROL PILLS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	YES NO	YES NO	YES NO	<input type="checkbox"/> LOCAL ANESTHETICS (EG. NOVOCAINE)	<input type="checkbox"/> BARBITURATES	<input type="checkbox"/> ASPIRIN	<input type="checkbox"/> PENICILLIN OR OTHER ANTIBIOTICS	<input type="checkbox"/> SEDATIVES	<input type="checkbox"/> OTHER _____	<input type="checkbox"/> SULFA DRUGS	<input type="checkbox"/> IODINE	
YES NO	YES NO	YES NO											
<input type="checkbox"/> LOCAL ANESTHETICS (EG. NOVOCAINE)	<input type="checkbox"/> BARBITURATES	<input type="checkbox"/> ASPIRIN											
<input type="checkbox"/> PENICILLIN OR OTHER ANTIBIOTICS	<input type="checkbox"/> SEDATIVES	<input type="checkbox"/> OTHER _____											
<input type="checkbox"/> SULFA DRUGS	<input type="checkbox"/> IODINE												

11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

<p>YES NO</p> <p><input type="checkbox"/> HIGH BLOOD PRESSURE</p> <p><input type="checkbox"/> HEART ATTACK</p> <p><input type="checkbox"/> RHEUMATIC FEVER</p> <p><input type="checkbox"/> SWOLLEN ANKLES</p> <p><input type="checkbox"/> FAINTING / SEIZURES</p> <p><input type="checkbox"/> ASTHMA</p> <p><input type="checkbox"/> LOW BLOOD PRESSURE</p> <p><input type="checkbox"/> EPILEPSY / CONVULSIONS</p> <p><input type="checkbox"/> LEUKEMIA</p> <p><input type="checkbox"/> DIABETES</p> <p><input type="checkbox"/> KIDNEY DISEASES</p> <p><input type="checkbox"/> AIDS OR HIV INFECTION</p> <p><input type="checkbox"/> THYROID PROBLEM</p>	<p>YES NO</p> <p><input type="checkbox"/> HEART DISEASE</p> <p><input type="checkbox"/> CARDIAC PACEMAKER</p> <p><input type="checkbox"/> HEART MURMUR</p> <p><input type="checkbox"/> ANGINA</p> <p><input type="checkbox"/> FREQUENTLY TIRED</p> <p><input type="checkbox"/> ANEMIA</p> <p><input type="checkbox"/> EMPHYSEMA</p> <p><input type="checkbox"/> CANCER</p> <p><input type="checkbox"/> ARTHRITIS</p> <p><input type="checkbox"/> JOINT REPLACEMENT OR IMPLANT</p> <p><input type="checkbox"/> HEPATITIS / JAUNDICE</p> <p><input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE</p> <p><input type="checkbox"/> STOMACH TROUBLES / ULCERS</p>	<p>YES NO</p> <p><input type="checkbox"/> CHEST PAINS</p> <p><input type="checkbox"/> EASILY WINDED</p> <p><input type="checkbox"/> STROKE</p> <p><input type="checkbox"/> HAY FEVER / ALLERGIES</p> <p><input type="checkbox"/> TUBERCULOSIS</p> <p><input type="checkbox"/> RADIATION THERAPY</p> <p><input type="checkbox"/> GLAUCOMA</p> <p><input type="checkbox"/> RECENT WEIGHT LOSS</p> <p><input type="checkbox"/> LIVER DISEASE</p> <p><input type="checkbox"/> HEART TROUBLE</p> <p><input type="checkbox"/> RESPIRATORY PROBLEMS</p> <p><input type="checkbox"/> OTHER _____</p>
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COMMENTS
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SIGNATURE OF DENTIST _____ DATE _____

PATIENT DENTAL HISTORY

<p>1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?</p> <p style="padding-left: 20px;">A) CLICKING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 20px;">B) PAIN (JOINT, EAR, SIDE OF FACE)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 20px;">C) DIFFICULTY IN OPENING OR CLOSING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 20px;">D) DIFFICULTY IN CHEWING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>8. DO YOU HAVE FREQUENT HEADACHES? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>9. DO YOU CLENCH OR GRIND YOUR TEETH? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>12. HAVE YOU HAD ANY ORTHODONTIC WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
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SIGNATURE	<p>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.</p> <p style="text-align: center;">X _____</p>
	<p>PATIENT, PARENT OR GUARDIAN _____ DATE _____</p>