Patient Information Form

Name ____ Date ______________
First Middle Last

Address ______________________ City ______________ State ________ Zip ________

Cell # ______________ Home phone ______________ Birthdate ______________

Email ______________________ Soc. Security # ______________________

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

If college student, F.T/P.T., name of school ______________ City ______________ State ________

Patient or parent's employer ______________________ Work phone ______________

Business address ______________ City ______________ State ________ Zip ________

Spouse or parent's name ______________ Employer ______________ Work phone ______________

Whom may we thank for referring you ______________________________

Person to contact in case of an emergency ______________________ Phone ______________

Responsible Party

Name of person responsible for this account ______________________ Relationship to patient ______________

Address ______________________________ Home phone ______________

Driver's license # ______________ Birth Date ______________ Soc. Security # ______________

Email Address: ______________________________

Employer ______________________________ Work phone ______________

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

Insurance Information

Name of insured ______________________________ Relationship to patient ______________

Birthdate ______________ Soc. Security # ______________ Date employed ______________

Name of employer ______________ Union or local # ______________ Work phone ______________

Employer address ______________ City ______________ State ________ Zip ________

Insurance Co. ______________ Tel. # ______________ Grp. # ________ Policy/I.D.# ______________

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 ______________ Soc. Security # ______________ Date employed ______________

Name of employer ______________ Union or local # ______________ Work phone ______________

Employer address ______________ City ______________ State ________ Zip ________

Insurance Co. ______________ Tel. # ______________ Grp. # ________ Policy/I.D. # ______________

Ins. Co. address ______________ City ______________ State. ________ Zip ________

How much is your deductible ______________ How much have you used ______________ Max annual benefit ______________

X______________________________ ______________________

Signature of patient (or parent, if minor) **Patient number**

MEDICAL HISTORY

PATIENT NAME ____ Birth Date ___________________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______________________
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______________________
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______________________
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______________________
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ______________________
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: ____

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ______________________

Comments: ____
____
____
____
____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________________ DATE ________________

Dental History

Patient Name____ Date of last visit_______________________________

What concerns you most about your teeth? ____

Yes No Are you presently in any dental pain?____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _________________________________

Yes No Have you ever lost or chipped any teeth?____

Yes No Have there been any injuries to face, mouth, or teeth? ____

Yes No Is any part of your mouth sensitive to temperature? Where? _______________________________________

Yes No Is any part of your mouth sensitive to pressure? Where?____

Yes No Do your gums bleed when you brush? ____

Yes No Do you have any type of thumb or tongue habit? ____

Yes No Are you a mouth breather? ____

Yes No Have you ever seen an orthodontist? If yes, who and when?_______________________________________

Yes No What is your attitude toward receiving orthodontic treatment? ____________________________________

Yes No Has anyone in your family received orthodontic treatment? _______________________________________
How did they feel about the result?____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? ______________________

Yes No Are you aware of your jaw clicking or popping? ____

Yes No Are you aware of clenching your teeth during the day? ____

Yes No Have you ever been told that you grind your teeth? ____

Yes No Do you have "tension" headaches? ____

Yes No Have you ever experienced chronic ringing in your ears? ____

Yes No If the patient is under age 16, height of parents? Mom______ Dad______

Yes No Are you aware that some appointments will be during school/work hours? ___________________________
Please list some hobbies or interests ____

Female Patients only:

Yes No Are you pregnant? ____

Yes No Has menstruation started? ____

Signature: ____Date: ____________________