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PATIENT INFORMATION AND HEALTH HISTORY

DATE OF BIRTH _____ AGE _____

PATIENT'S NAME _____ NICKNAME _____

PATIENT'S ADDRESS _____ HM. PHONE _____

CITY _____ STATE _____ ZIP _____ CELL PHONE _____

EMAIL _____ REFERRED BY _____

PARENT/GUARDIAN FOR PATIENT UNDER 18 YEARS _____

DENTAL INSURANCE PLAN _____ BUSINESS PHONE _____

POLICY HOLDER _____ PH DOB _____ PH SS# _____

PH'S EMPLOYER _____ PATIENT'S SS# _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

PHONE # _____ PHARMACY: _____

DENTAL HISTORY

HAS THE PATIENT EVER BEEN TO A DENTIST PRIOR TO TODAY'S VISIT? ☐ YES ☐ NO

DENTIST'S NAME _____ PHONE _____

CHIEF ORAL COMPLAINT _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums. How long _____
- ☐ Food impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ☐ Unusual sounds in ear while eating
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Unfavorable dental experience
- ☐ Complications from extractions
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Oral habits, i.e., fingernail biting, cheek biting, etc.
- ☐ Cigarettes, pipe or cigar smoking
- ☐ Texture of toothbrush _____
- ☐ Frequency of brushing _____
- ☐ Dental Floss
- ☐ Inter dental stimulators
- ☐ Water jet device
- ☐ Disclosing tablets or solution
- ☐ Fluoride supplements
- ☐ Coffee or tea drinking

MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM. _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Allergies to drugs
- ☐ Allergies to anesthetics
- ☐ Any heart ailments
- ☐ High blood pressure
- ☐ Neurological problems
- ☐ Radiation treatments
- ☐ Excessive bleeding from cut or extraction
- ☐ Anemia or blood problems
- ☐ Arthritis
- ☐ Asthma
- ☐ Any Food Allergies
- ☐ Medications (indicate on medication page)
- ☐ Hay fever or allergies in general
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Liver problems or hepatitis
- ☐ Malignancies
- ☐ Psychiatric care/emotional problems
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid
- ☐ Recent Joint Replacement
- ☐ Eye disorder
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer or colitis
- ☐ Pregnancy
  If so, what month _____
- ☐ Venereal disease
- ☐ Epilepsy
- ☐ HIV or Aids
- ☐ Artificial joints
- ☐ Recent Hospitalization
- ☐ Abuse/neglect
- ☐ Latex allergy

*** FOR THIRD PARTY ASSIGNMENT: IT IS YOUR RESPONSIBILTY TO ENSURE PAYMENT IN FULL WITHIN 60 DAYS OF DATE OF SERVICE, REGARDLESS OF COVERAGE BY THIRD PARTY.***

Should it be necessary to change an appointment, our patients must give us 24 hours notice. Although WE DO CHARGE FOR BROKEN APPOINTMENTS, it is never our wish to do so.

SIGNATURE _____ DATE _____