PATIENT INFORMATION AND HEALTH HISTORY

PATIENT'S NAME _____ SS # _____ DATE OF BIRTH _____ SEX: M F

CIRCLE: SINGLE MARRIED DIVORCED WIDOWED

ADDRESS _____ PHONE _____

STREET CITY STATE ZIP CELL # _____

EMPLOYED BY _____ BUSINESS PHONE _____

SPOUSE'S NAME _____ SS# _____ DATE OF BIRTH _____

EMPLOYED BY _____ BUSINESS PHONE _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ METHOD OF PAYMENT: CASH CHECK CREDIT CARD

HOW DID YOU FIND OUR OFFICE? _____

DENTAL HISTORY

LAST DENTAL CLEANING AND EXAM _____ PREVIOUS DENTIST _____

PHONE # / CITY / STATE OF PREVIOUS DENTIST _____

HAVE YOU EVER HAD A BAD DENTAL EXPERIENCE? Y / N EXPLAIN _____

DENTAL CONCERN OR PURPOSE OF VISIT? _____

IS THERE ANYTHING ABOUT YOUR SMILE OR TEETH YOU DO NOT LIKE OR WOULD LIKE TO CHANGE? _____

HAVE YOU EVER CONSIDERED BLEACHING OR WHITENING YOUR TEETH? _____

HAVE YOU EVER BLEACHED YOUR TEETH? Y / N WHEN? _____ HOW? _____

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. Area?
- ❒ Dry mouth
- ❒ Swelling or lumps in mouth
- ❒ Mouth breathing
- ❒ Bad breath
- ❒ Unpleasant taste
- ❒ Clenching or grinding
- ❒ Peridontal treatment. When?
- ❒ Orthodontic treatment. When?
- ❒ Pain around ear
- ❒ Smoking, type frequency
- ❒ Texture of toothbrush
- ❒ Frequency of brushing
- ❒ Dental floss
- ❒ Frequent blisters on lips or mouth
- ❒ Unusual sounds in ear while eating

MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM _____

Do you have or have you ever had any of the following: (Please answer all questions.)

Yes No		Yes No		Yes No	
❒❒	Heart disease (describe)	❒❒	Asthma	❒❒	Stroke (when)
❒❒	High blood pressure	❒❒	Hay fever or allergies in general	❒❒	Thyroid problem
❒❒	Heart murmur/premed_____	❒❒	Anemia or blood problems	❒❒	Diabetes
❒❒	Mitral valve prolapse/premed_____	❒❒	Kidney problems	❒❒	Aids, HIV, ARC
❒❒	Rheumatic fever	❒❒	Liver problems or hepatitis	❒❒	Arthritis
❒❒	Pacemaker	❒❒	Cancer: Type_____	❒❒	Ulcer of colitis
❒❒	Angina or chest pain	❒❒	Psychiatric care / emotional problems	❒❒	Tuberculosis
❒❒	Joint replacement/premed_____	❒❒	Neurological disorder	❒❒	Radiation treatments
❒❒	Excessive bleeding form cut or extracton	❒❒	Sinus problems	❒❒	Pregnancy - If so, what month?
❒❒	Allergies to drugs, list_____	❒❒	Venereal disease	❒❒	Hospital stay overnight
❒❒	Allergies to anesthetics, describe_____				

List any current medical treatment, surgery or hospitalization _____

List all medications currently taking with dosage and frequency _____

The above information is correct to the best of my knowledge.

SIGNATURE _____ **DATE** _____

(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)