We are complimented that you have selected us to provide dental care for you and your family.

## Patient Information

Date _____

Patient's Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Name of nearest relative not living with you _____

Complete Address _____ Phone _____

## Responsible Party Information

Name _____ (Last) _____ (First) _____ (Middle) _____ (Marital Status)

Residence _____ (Street) _____ (City) _____ (State) _____ (Zip)

Mailing Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____ (Street) _____ (City) _____ (State) _____ (Zip)

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ (Last) _____ (First) _____ (Middle) Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

## Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____ Ph. # _____

Is policy connected with your union? Yes _____ No _____ Name of Union _____ Local No. _____

Do you have dual coverage? Yes _____ No _____ If yes: **Please complete the following secondary insurance information.**

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Ph. # _____

Insured's Employer _____ Ph. # _____

## Dental Information

Do your gums bleed when you brush? Yes _____ No _____

Are your teeth sensitive to heat or cold? Yes _____ No _____ Pressure Yes _____ No _____ Sweets Yes _____ No _____

Do you grind or clench your teeth? Yes _____ No _____

Do you have any fear of dental work? Yes _____ No _____

Date of last dental examination _____ What was done at that time? _____

How would you describe your current dental problem? _____

How do you feel about the appearance of your teeth? _____

**Please complete back page**

## Medical Information

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the past two years? ..... YES NO
3. Have you been under the care of a medical doctor during the past two years? ..... YES NO
   Physician's Name _____ Phone No. _____
   Address _____
4. Have you taken any medication or drugs during the past two years? ..... YES NO
5. Are you now taking any medication or drugs? ..... YES NO
   If yes, please list: _____
6. Are you sensitive or allergic to any medication or anesthetics? ..... YES NO
   If yes, please list: _____
7. Indicate which of the following you have had or have at present. Circle "yes or "no" to each item.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart Failure | YES | NO | Artificial Joints (hip, knee, etc.) | YES | NO | Hepatitis B (serum) | YES | NO |
| Heart Disease or Attack | YES | NO | Kidney Trouble | YES | NO | Venereal Disease | YES | NO |
| Angina Pectoris | YES | NO | Ulcers | YES | NO | A.I.D.S. | YES | NO |
| Congenital Heart Disease | YES | NO | Diabetes | YES | NO | H.I.V. Positive | YES | NO |
| Heart Murmur | YES | NO | Thyroid Problems | YES | NO | Cold Sores/Fever Blisters | YES | NO |
| High Blood Pressure | YES | NO | Glaucoma | YES | NO | Blood Transfusion | YES | NO |
| Arteriosclerosis | YES | NO | Cancer | YES | NO | Hemophilia | YES | NO |
| Mitral Valve Prolapse | YES | NO | Emphysema | YES | NO | Anemia | YES | NO |
| Artificial Heart Valve | YES | NO | Chronic Cough | YES | NO | Sickle Cell Disease | YES | NO |
| Heart Pacemaker | YES | NO | Tuberculosis | YES | NO | Bruise Easily | YES | NO |
| Heart Surgery | YES | NO | Asthma | YES | NO | Liver Disease | YES | NO |
| Rheumatic Fever | YES | NO | Hay Fever | YES | NO | Yellow Jaundice | YES | NO |
| Arthritis | YES | NO | Allergies or Hives | YES | NO | Epilepsy or Seizures | YES | NO |
| Rheumatism | YES | NO | Sinus Trouble | YES | NO | Fainting or Dizzy Spells | YES | NO |
| Cortisone Medicine | YES | NO | Radiation Therapy | YES | NO | Nervousness | YES | NO |
| Drug Addiction | YES | NO | Chemotherapy | YES | NO | Tumors | YES | NO |
| Stroke | YES | NO | Hepatitis A (infectious) | YES | NO | Developmentally Disabled | YES | NO |

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... YES NO
9. Do your ankles swell during the day? ..... YES NO
10. Do you use more than two pillows to sleep? ..... YES NO
11. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
12. Do you ever wake up from sleep and feel short of breath? ..... YES NO
13. Are you on a special diet? ..... YES NO
14. Do you have or have you had any disease, condition, or problem not listed? ..... YES NO
    If yes, please list: _____

**FOR WOMEN ONLY:**

Are you pregnant? ☐ Yes, what month? _____ ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and the the best of my knowledge.

Patient Signature _____ Date _____

**Reviewed By Doctor** _____ **Date** _____ **BP** _____

**History Review and Significant Findings:** _____

## Medical Updates

**I have read my MEDICAL HISTORY dated** _____ **and confirm that it adequately states past and present conditions.**

| DATE | EXCEPTIONS | | PATIENT'S SIGNATURE | BP | REVIEWED BY |
|---|---|---|---|---|---|
| _____ | _____ | None ☐ | _____ | _____ | Dr. _____ |
| _____ | _____ | None ☐ | _____ | _____ | Dr. _____ |
| _____ | _____ | None ☐ | _____ | _____ | Dr. _____ |
| _____ | _____ | None ☐ | _____ | _____ | Dr. _____ |
| _____ | _____ | None ☐ | _____ | _____ | Dr. _____ |
| _____ | _____ | None ☐ | _____ | _____ | Dr. _____ |
| _____ | _____ | None ☐ | _____ | _____ | Dr. _____ |