Patient Information

Patient Name:_____Date:_____
Last First MI (Preferred Name)

Gender: M F Marital Status: ☐ Married ☐ Single Birth Date:_____Social Security #:_____

Driver's License #:_____E-Mail Address:_____

Address:_____
Street Apartment #

_____
City State Zip Code

Phone #'s: Home_____Work_____Ext_____Best time to call:_____

FAX_____Pager_____Other_____

Referral Information

Name of person, office or other source referring you to our office:

_____

Spouse or Responsible Party Information

Name:_____Relationship to patient: ☐ Spouse ☐ Parent ☐ Other _____
Last First MI

Gender: M F Marital Status: ☐ Married ☐ Single Birth Date:_____Social Security #:_____

Driver's License #:_____E-Mail Address:_____

Address:_____
Street Apartment #

_____
City State Zip Code

Phone #'s: Home_____Work_____Ext_____Best time to call:_____

FAX_____Pager_____Other_____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name:_____

Address:_____
Street City State Zip Code Phone

Insurance Information

Primary:

Name of Insured:_____
Last First MI

Insured's Birthdate:_____SS #:_____Group #:_____

Insured's Address:_____
Street City State Zip Code

Insured's Employer Name:_____

Address:_____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Company/Plan Name and Address:_____

_____

Secondary:

Name of Insured:_____
Last First MI

Insured's Birthdate:_____SS #:_____Group #:_____

Insured's Address:_____
Street City State Zip Code

Insured's Employer Name:_____

Address:_____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Company/Plan Name and Address:_____

_____

Medical Information

Please indicate if you have or have had any of the following diseases or problems.

Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Y N

Are you taking or scheduled to begin taking either of the medications, alendronate **(Fosamax)** or risedronate **(Actonel)** for osteoporosis or Paget's disease? Y N

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphontes **(Aredia or Zometa)** for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Y N

WOMEN ONLY - Are you:
Taking birth control pills or hormonal replacement? Y N
Pregnant? Y N
If yes, number of weeks _____

Allergies - Are you allergic to or have had a reaction to:
Acrylic Y N
Aspirin Y N
Codeine Y N
Erythromycin Y N
Latex Y N
Local Anesthetics Y N
Penicillin Y N
Tetracycline Y N
Metals:
If yes, specify: _____ Y N
Other allergy not listed:
If yes, specify: _____ Y N

List any prescription or over the counter medicine(s) you are presently taking: _____
_____

Please indicate if you have or have had any of the following diseases or problems.

Artificial (Prosthetic) Heart Valve Y N
Previous Infective Endocarditis Y N
Damaged Valves in Transplanted Heart Y N
Congenital Heart Disease (CHD):
Unrepaired, cyanotic CHD Y N
Repaired (completely) in last 6 months Y N
Repaired CHD with residual defects Y N

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Cardiovascular Disease Y N
Angina Y N
Congestive Heart Failure Y N
Damaged Heart Valves Y N
Heart Attack Y N
Heart Murmur Y N
Low Blood Pressure Y N
High Blood Pressure Y N
Other Congenital Heart Defects Y N
Mitral Valve Prolapse Y N
Pacemaker Y N
Rheumatic Fever Y N
Rheumatic Heart Disease Y N
Abnormal Bleeding Y N
Anemia Y N
Coumadin/Blood Thinner Therapy Y N
AIDS or HIV Infection Y N

Arthritis Y N
Autoimmune Disease Y N
Rheumatoid Arthritis Y N
Systemic Lupus Erythematosus Y N
Asthma Y N
Emphysema Y N
Tuberculosis Y N
Pulmonary Shunts Y N
Cancer/Chemotherapy/Radiation Treatment Y N
Diabetes Y N
Fen-Phen (fenfluramine/phentermine) Therapy Y N
Eating Disorder Y N
Gastrointestinal Disease/Stomach Problems Y N
Thyroid Problems Y N
Stroke Y N
Hepatitis, Jaundice or Liver Disease Y N
Kidney Problems Y N
Sexually Transmitted Disease Y N
Osteoporosis Y N
Drug/Alcohol Abuse Y N
Epilepsy Y N
Neurological Disorders
If yes, specify: _____ Y N
Mental Health Disorders
If yes, specify: _____ Y N
Other medical condition not listed:
If yes, specify: _____ Y N

Have you had any previous hospitalizations or surgeries?: Y N If yes, specify: _____
Are you currently under the care of a physician? Y N If yes, please explain: _____
List the name of your physician and phone number: _____
List the name and phone number of someone to notify in case of an emergency: _____

Authorization and Consent

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes. I hereby consent to and authorize the dental office to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I further understand that payment is due at the time of treatment unless prior arrangements have been made. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

Patient or Responsible Party Signature:_____ Date:_____

Office Use Only

I verbally reviewed the medical/dental information with the patient named herein.
Dentist Signature:_____ Date:_____

Dental History

Primary reason for this appointment: □ *Examination* □ *Emergency* □ *Consultation*

Patient Name:_____ **Date:**_____

(The following responses are for the patient)

Do you have a specific dental problem today? ..... Y N

If yes, please explain:_____

Do you have dental examinations on a routine basis? ..... Y N

Last visit?:_____

Do you brush your teeth on a routine basis? ..... Y N

How often?:_____

Do you floss on a routine basis? ..... Y N

How often?:_____

Do you like your smile? ..... Y N

If no, why?:_____

Do you think you have active tooth decay? ..... Y N

Do you think you have gum disease? ..... Y N

Do your gums bleed? ..... Y N

Do you have any loose teeth? ..... Y N

Have you ever had any periodontal (gum) treaments? ..... Y N

If yes, when?:_____ where?:_____

Do you want to keep your remaining teeth? ..... Y N

Do you ever have clicking, popping, or discomfort in the jaw joint? ..... Y N

Do you brux or grind your teeth? ..... Y N

Do you smoke or chew tobacco? ..... Y N

Have you ever had orthodontic (braces) treatment? ..... Y N

Do you wear dentures or partials? ..... Y N

If yes, are you satisfied with them?:_____

Have you had any problems associated with previous dental treatment? ..... Y N

If yes, please explain: _____

_____

Name of previous dentist (optional):_____

Date of last full mouth x-rays (16 small films or panoramic):_____

To the best of my knowledge, I certify that the information given above is correct.

Signature of Patient/Legal Guardian:_____

Dentist Signature:_____

Medical History Update (For Office Use Only)

Date:_____ Comments:_____ Initials:_____

Date:_____ Comments:_____ Initials:_____

Date:_____ Comments:_____ Initials:_____

Date:_____ Comments:_____ Initials:_____

Date:_____ Comments:_____ Initials:_____