Patient History Information

Patient Information (CONFIDENTIAL)

Date_____

SS# _____

Name _____ Birthdate _____Home Phone_____

Address _____ City _____State _____Zip_____

Email _____Cell Phone _____

Do you prefer to receive calls at your: ☐Home ☐Work ☐Cell Phone

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

If student, Name of School/College _____City _____State _____ ☐ Full Time ☐Part Time

Patient or Parent/Guardian's Employer_____ Work Phone _____

Business Address _____City _____State_____Zip _____

Spouse or Parent/Guardian's Name _____Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐MasterCard ☐ Discover ☐ Amex

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Insurance Information

Name of Subscriber _____ Relationship to Patient _____

Birthdate _____SS#____Date Employed _____

Name of Employer _____Work Phone _____

Address of Employer _____City _____State _____Zip _____

Insurance Company _____Group # _____Policy/ID # _____

Ins. Co. Address _____City _____State_____Zip _____

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. (Please circle your responses)

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today: _____

Have there been any changes in your general health in the past year? Yes No

If yes, please describe: _____

Are you now under a physician's care for a particular problem at this time? Yes No

If yes, why? _____ Date of last physical exam ____/_____/_____

Have you ever been hospitalized or had a serious illness? Yes No

If yes, why?_____

Patient Medical History

Do you have or have you ever had:
(Please circle any/all that may apply)

Congenital Heart Disease, Cardiovascular Disease, Heart Attack, Heart Murmur, Coronary Artery Disease, Angina, High/Low Blood Pressure, Stroke, Irregular Heartbeat, Heart Surgery, Cardiac Pacemaker, Mitral Valve Prolapse?	Yes	No	Lung Disease, Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing, Easily Winded?	Yes	No
			Glaucoma?	Yes	No
Joint Replacement or Implants placed anywhere in the body (Heart Valve, Pacemaker, Hip, Knee)?	Yes	No	Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? Sexually Transmitted Disease? AIDS? HIV Infection?	Yes	No
Kidney Disease or Kidney Failure, requiring Dialysis?	Yes	No	Liver Disease (Jaundice, Hepatitis A, B, or C)?	Yes	No
Thyroid Problem?	Yes	No	Diabetes?	Yes	No
Stomach Ulcers or Colitis?	Yes	No	Arthritis?	Yes	No
Radiation to the head or neck for cancer treatment?	Yes	No	Significant Weight Loss or Gain?	Yes	No
Osteoporosis or Osteopenia?	Yes	No	Seizures, Convulsions, Epilepsy, Fainting or Dizziness?	Yes	No
Sinus or Nasal problems? Allergies?	Yes	No			

Any other disease, Chemotherapy or Transplant Operation? Cancer? Leukemia? Yes No
If so, where? _____, and when was the date of your last treatment? _____

Do you have any other disease, condition or problem <u>not listed above</u> that you think the doctor should know about? Yes No

If yes, please explain: _____

Family Medical History

Do you have a family history of any of the following? (If yes, indicate the relationship)

Diabetes?	Yes	No	Relationship _____	Cancer?	Yes	No	Relationship _____
Heart Disease?	Yes	No	Relationship _____	Bleeding Problems?	Yes	No	Relationship _____
Tumors?	Yes	No	Relationship _____	Lung Disease?	Yes	No	Relationship _____

Female Patients

Are you pregnant, or is there any chance you might be pregnant? Yes No If Yes, how far along_____
and expected due date _____

Are you nursing? Yes No
Are you taking oral contraceptives Yes No

Medications

Are you taking any of the following:

(If yes, please LIST ALL medications and indicate why you are taking it)

Antibiotics? _____ Yes No

Anticoagulants (Blood Thinners)? _____ Yes No

Heart Drugs? _____ Yes No

Steroids (Cortisone, Prednisone, etc.)? Yes No
Anti-anxiety Agents, Sedative-hypnotics and Antidepressants _____

Prescription Pain Medication? Yes No

Aspirin or drugs such as Motrin, Aleve, Ibuprofen? _____ Yes No

Insulin or Oral Anti-diabetic drugs? _____ Yes No

High Blood Pressure medications? _____ Yes No

Bisphosphonates (Fosamax, Boniva, Actonel), Antiangeogenic and/or Antiresorptive medications for Osteoporosis, Multiple Myeloma or other Cancers? If yes, list drugs used and time of use. Yes No
_____
_____

Please list any other medications you have taken or are currently taking <u>not listed above</u> including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals: _____

Allergies

Are you allergic to or have you had an adverse reaction to: (If yes, please list and/or circle)

Latex? (gloves used in dental office) _____ Yes No

Food products? _____ Yes No

Sedatives, Barbiturates? _____ Yes No

Codeine or other pain killers? _____ Yes No

Aspirin, Motrin, Aleve, or Ibuprofen? _____ Yes No

Penicillin, Sulfa Drugs, or other antibiotics? _____ Yes No

Have you or an immediate family member had any problem associated with Local Anesthesia, General Anesthesia, and/or Intravenous Sedation? Yes No If yes, which anesthetic? _____ Relationship? _____

Other drug allergies <u>not listed above</u>: (Iodine, Any Metals) _____

Social History

Have you ever smoked or chewed tobacco? Yes No If yes, for how long? _____

Have you ever sought professional care or been hospitalized for:

Drug Abuse? Yes No

Emotional Disorders? Yes No

Alcoholism? Yes No

Do you use:

Alcohol? Yes No How often? _____

Marijuana? Yes No How often? _____

Recreational Drugs? Yes No How often? _____

Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

1. Have you had any adverse effects from dental treatment? Yes No
2. Do you wish to talk to the doctor privately about anything? Yes No
3. Do your gums bleed while brushing or flossing? Yes No
4. Are your teeth sensitive to hot or cold liquids/foods? Yes No
5. Are your teeth sensitive to sweet or sour liquids/foods? Yes No
6. Do you feel pain to any of your teeth? Yes No
7. Do you have frequent headaches? Yes No
8. Frequent or recurring mouth sores? Yes No
9. Have you ever experience any of the following problems in your jaw?
   - Clicking Yes No
   - Pain (joint, ear, side of face) Yes No
   - Difficulty in opening or closing Yes No
   - Difficulty in chewing Yes No
10. Do you clench or grind your teeth? Yes No
11. Do you bite your lips or cheeks frequently? Yes No
12. Have you ever had any difficult extractions in the past? Yes No
13. Have you ever had any prolonged bleeding following extractions? Yes No
14. Have you had any orthodontic treatment? Yes No
15. Do you wear dentures or partials? Yes No

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments _____

_____

_____

_____Signature_____Date_____