

Welcome to our Practice!

Will you please help us by providing us with the following confidential information?

PATIENT INFORMATION:

E-mail Address: _____, Last Name: _____ First Name: _____

Preferred to be called: _____, Mailing Address: _____

Home Phone: _____, Work Phone: _____ Cell Phone: _____

City, State, Zip: _____ Date of Birth: _____

SS#: _____, Driver's License: _____ Sex: M F Occupation: _____

Employer: _____, Address, City State, Zip _____

Emergency Contact Name: _____ Phone # : _____

Spouse's Name: _____ Occupation: _____

Spouse's Address (if different than above): _____, City, State, Zip: _____

Spouse's Employer: _____ Address, City, State, Zip: _____

In the event that we must contact you for scheduling changes, etc, please indicate the best PHONE NUMBER during business hours to phone you:

Phone number: _____, Place _____ Time: _____

INSURANCE INFORMATION:

Primary Insurance Company : _____ Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Policy Holder Name: _____ SS#: _____ Birth date: _____

Group# or Policy # _____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for the purpose of facilitating the billing and reimbursement, directly to Dr. (Provider's Name) of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged.

Date: _____ Patient's Signature: _____

MEDICAL HEALTH HISTORY

PATIENT NAME: _____

A. CIRCLE YOUR ANSWERS (leave BLANK if you do not understand the question):

- 1. Yes No Are you in good health?
- 2. Yes No Has there been a change in your health within the last year? Explain: _____
- 3. Yes No Have you been hospitalized or had a serious illness in the last 5 years? Explain: _____

- 4. Yes No Are you being treated by a physician now? For what? _____

Name of your physician: _____ Date of last Medical Exam: _____

B. HAVE YOU EVER EXPERIENCED?

- | | |
|--|---|
| 5. Yes No Chest Pains | 16. Yes No Dizziness |
| 6. Yes No Swollen Ankles | 17. Yes No Ringing in ears |
| 7. Yes No Shortness of breath | 18. Yes No Frequent Headaches |
| 8. Yes No Recent weight loss, fever, night sweats | 19. Yes No Fainting spells |
| 9. Yes No Persistent cough, coughing up blood | 20. Yes No Blurred Vision |
| 10. Yes No Bleeding problems, bruising easily | 21. Yes No Seizures |
| 11. Yes No Sinus Problems | 22. Yes No Excessive thirst |
| 12. Yes No Difficulty swallowing | 23. Yes No Frequent urination |
| 13. Yes No Diarrhea, constipation, blood in stools | 24. Yes No Dry Mouth |
| 14. Yes No Frequent vomiting, nausea | 25. Yes No Jaundice |
| 15. Yes No Difficulty urinating, blood in urine | 26. Yes No Joint pain, stiffness |
| | 27. Yes No Sleep apnea or chronic snoring |

C. DO YOU HAVE OR HAVE YOU HAD:

- | | |
|---|--|
| 28. Yes No Heart disease | 39. Yes No HIV positive or AIDS-ARC |
| 29. Yes No Heart attack, heart defects | 40. Yes No Tumors, Cancer |
| 30. Yes No Heart murmur | 41. Yes No Arthritis, rheumatism |
| 31. Yes No Rheumatic fever | 42. Yes No Eye disease |
| 32. Yes No Stroke, hardening of arteries | 43. Yes No Skin disease |
| 33. Yes No High Blood Pressure | 44. Yes No Anemia |
| 34. Yes No TB, emphysema or other lung diseases | 45. Yes No VD (syphilis or gonorrhea) |
| 35. Yes No Hepatitis, A B C | 46. Yes No Herpes |
| 36. Yes No Stomach problems, ulcers | 47. Yes No Kidney, bladder diseases |
| 37. Yes No Diabetes | 48. Yes No Thyroid, adrenal diseases |
| 38. Yes No Family History of diabetes, heart problems, cancer | 49. ALLERGIES: to drugs, food, medications, metals, jewelry, acrylics; list the following allergies: |

D. DO YOU HAVE OR HAVE YOU HAD:

- | | |
|-------------------------------------|---|
| 50. Yes No Surgeries _____ | 55. Yes No Radiation Treatments |
| 51. Yes No Blood Transfusions _____ | 56. Yes No Chemotherapy |
| 52. Yes No Artificial Joint _____ | 57. Yes No Prosthetic heart valve |
| 53. Yes No Contact Lenses _____ | 58. Yes No Pacemaker |
| 54. Yes No Psychiatric Care _____ | 59. Yes No Women only: Birth Control Pills |
| | 60. Yes No Women only: Pregnant or nursing |

E. DO YOU TAKE OR HAVE TAKEN:

- 61. Yes No Recreational drugs
- 62. Yes No Alcohol
- 63. Yes No Tobacco in any forms
- 64. Yes No Phen Phen diet Pills or any other diet pills

VITAMINS & MEDICATIONS: _____

F. ALL PATIENTS:

- 65. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

- 66. Yes No Have you ever been told by a physician or dentist that you need to pre-medicated prior to any dental treatment?

DENTAL HEALTH HISTORY

67 H. Name of you Dentist: _____ How long since you were last seen? _____

68. Is keeping your teeth important to you? [Y] [N] If yes, why? _____

69. On a scale of 1-10, 10 being the best, where would you rate your smile?

70. On a scale of 1-10, 10 being the best, where you rate your oral health?

71. Have you experienced any of the following problems:

Bleeding gums [Y] [N],

Bad Breath or sour taste in mouth [Y] [N]

Burning sensations in mouth [Y] [N]

Soreness in jaw [Y] [N],

Is it hard for you to open wide? [Y] [N]

Clicking or popping in jaw [Y] [N]

Had your parents suffered from Gum Disease? [Y] [N]

Did you ever wear braces? [Y] [N]

Oral Surgery of any kind? [Y] [N]

Sensitivity to Hot & Cold [Y] [N]

Snoring [Y] [N]

Food catching between teeth [Y] [N]

Grinding of Teeth [Y] [N]

Pain/soreness around ears, eyes, face [Y] [N]

Stiff neck muscles [Y] [N]

Did you parents wear dentures/partials? [Y] [N]

Ever been injured in your mouth or head? [Y] [N]

Do you smoke or chew tobacco? [Y] [N]

72 Does having dental treatment make you afraid or nervous? [Y] [N] If yes, what specific things bother you? _____

73. Is the brightness of your teeth important to you? [Y] [N]

74. If you could change anything about your smile which of the following would you want] ?

Whiter [Y] [N],

Close space or spaces [Y] [N],

Replace chipped teeth [Y] [N]

Replace missing teeth [Y] [N]

Replace old crowns [Y] [N]

Remove silver fillings [Y] [N]

Remove Stains/Spots on teeth [Y] [N]

Excess showing of Teeth [Y] [N]

Replace old plastic filling(s) [Y] [N]

Straighter [Y] [N]

Less Gum showing [Y] [N]

Reshape/resize my teeth [Y] [N]

75. Fill in this question for us please: Where do you see yourself and your overall oral health and/or your smile in the next 5 to 10 years?

Please circle the following which are important to you when making your dental health decision.

Convenience

Appearance

Relationship with Dental Team

Finances

Time

Quality of care

What insurance covers

Health

Detailed treatment explanations

Fear or Anxiety

Comfort

Technology