# PATIENT INFORMATION AND HEALTH HISTORY

Date______________________

**PATIENT'S NAME**: Dr / Mr / Mrs / Ms / Miss____________________________________________________________DATE OF BIRTH________________________
Last First Middle Initial

ADDRESS__________________________________________________________________________________HOME PHONE#____________________________
Number Street City Zip

SS#__________________DRIVER LICENSE#___________________DAYTIME / CELL PHONE#___________________EMAIL ADDRESS____________________

REFERRED BY___________________________EMPLOYED BY________________________________BUSINESS PHONE#______________________________

**PERSON RESPONSIBLE FOR THIS ACCOUNT**_____________________________SS#________________DOB____________RELATIONSHIP_______________

**DENTAL INSURANCE PLAN**_______________________PRIMARY CARD HOLDER'S NAME:_____________________HIS/HER PHONE #________________

## DENTAL HISTORY

CHIEF ORAL COMPLAINT ______________________________________________________________________________________________________________

DATE OF LAST DENTAL EXAM________________________________ANY PREVIOUS MAJOR DENTAL TREATMENT: ☐ NO or ☐ YES (WHEN___________,

TYPE OF TREATMENT________________________________________________________________________________)

PLEASE CHECK ALL THAT APPLY TO YOU WITH A (√ )

☐ Cosmetic concern (teeth not white/straight/pretty) ________
☐ Teeth sensitive to cold, heat, sweets or pressure
☐ Bleeding gums. How frequent___________
☐ Food impacting
☐ Clenching or Grinding
☐ Burning of Tongue
☐ Swelling or Lumps in mouth
☐ Frequent blisters on lips or mouth
Pain around ear / TMJ problem
☐ Bad breath
☐ Unpleasant taste
☐ Mouth breathing
☐ Periodontal treatment year ________
☐ Orthodontic treatment year________
☐ Complication from extractions
☐ Other dental treatment complication history________________
☐ Oral habits, i.e., fingernail biting, cheek biting, etc.
☐ Cigarettes, Pipe or Cigar smoking / Tobacco chewing
☐ Texture of toothbrush: soft / medium / hard
☐ Frequency of brushing:________times per day
☐ Frequency of dental flossing:________times per day
☐ Fluoride supplements
☐ Wearing dentures / partials

## MEDICAL HISTORY

PHYSICIAN'S NAME________________________PHONE #________________DATE OF LAST PHYSICAL EXAM__________CURRENT AGE ______________

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING - PLEASE CHECK ALL THAT APPLY TO YOU WITH A (√ )

☐ Allergies to latex / drugs / anesthetic list: ________________________________
☐ Excessive bleeding from cut / extractions
☐ Anemia
☐ Heart valve replacement / defect type:________________
☐ Rheumatic fever
☐ Pre medicate for dental procedures
☐ Hepatitis A / B / C
☐ HIV / AIDS
☐ Tuberculosis
☐ Osteoporosis / Osteopenia
☐ Joint Replacement of________year______
☐ Thyroid disease__________________
☐ Cancer of _____________________
☐ Radiation / Chemo treatments of______
☐ Gastric ulcer or Colitis
☐ Kidney problems
☐ Sinus problem
☐ Asthma
☐ Tonsillitis
☐ Eye disease / glaucoma
☐ Diabetes
☐ Heart attack, if so what year___________
☐ Pacemaker
☐ High blood pressure
☐ Stroke (year occurred____________)
☐ Seizure / Epilepsy
☐ Psychiatric care / emotional problem _________
☐ Currently pregnant; If so, due ate______________
☐ Others (describe:________________________)
☐ List All Current Medicine that you are taking including over the counter meds: ________________________________________________________

**********

**APPOINTMENTS**: A minimum of $75 charge will be made for failed or cancelled appointment without prior notification of 48 hours (2 Business Days). Once an appointment is made, please remember this time has been reserved for you.

**INSURANCE**: To avoid misunderstanding regarding dental insurance, we wish our patients to know that we do not render our services on the basis that insurance companies will pay all dental services. Each dental treatment plan is individualized for the individual patient. All professional services rendered are charged directly to the patients and that patients are personally responsible for payment of all fees. However, we will prepare necessary forms or reports to help you obtain your insurance benefits.

***THANK YOU FOR CHOOSING US AS YOUR DENTAL HEALTH PROVIDER!!!***

SIGNATURE_______________________________________DATE_______________________
(Parent or guardian if patient is a minor)

(Form 01/11)