Patient History

Name: _____ Date of Birth: _____ Date: _____
First Last Mi Suffix

I prefer to be called: _____ ☐ Male ☐ Female

Physician's Name or Place of Care: _____

Are you currently under the care of a physician? ☐ YES ☐ NO

If yes, please explain: _____

_____

Please list any **MEDICATIONS** you currently take, prescribed or over the counter and the dosages:

_____ DOSE: _____ _____

_____ DOSE: _____ _____

_____ DOSE: _____ _____

_____ DOSE: _____ _____

Women Only:

Are you pregnant? ☐ YES ☐ NO If yes, due date: _____

Are you nursing? ☐ YES ☐ NO

Current or Previous Conditions

Select any of the following if you presently have or have had in the past

Medical Alerts:

- ☐ Allergic to Latex
- ☐ Allergic to Novocain
- ☐ Allergic to Penicillin
- ☐ Allergies to any medicine: _____
- ☐ Other Allergies:_____

Medical Conditions:

- ☐ Pre-medication Required
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Congenital Heart Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Heart Surgery
- ☐ Other Heart Issues:_____

_____

- ☐ Stroke
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Anemia
- ☐ Hemophilia/Blood Disease
- ☐ Excessive Bleeding when cut
- ☐ Gastrointestinal Upset
- ☐ Rheumatic Fever
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Thyroid/Parathyroid
- ☐ Dry Mouth
- ☐ Excessive Thirst
- ☐ Hepatitis A,B or C
- ☐ Cancer
- ☐ Chemotherapy or Radiation
- ☐ Chemical Dependency
- ☐ Cortisone Treatment
- ☐ Cold Sore/Fever Blister
- ☐ Venereal Disease
- ☐ Ulcers
- ☐ Arthritis Rheumatism
- ☐ Tuberculosis
- ☐ Ehmphysema
- ☐ Asthma
- ☐ Sinus Trouble
- ☐ Sleep Apnea
- ☐ HIV Positive
- ☐ Swelling of Feet/Ankles
- ☐ Osteoporosis
- ☐ Artificial Joint Replacement
  Date: _____
- ☐ Psychiatric Care
- ☐ Epilepsy
- ☐ Extreme Nervousness
- ☐ Fainting or Dizziness

Other: _____

About You

Email Address: _____

Home Address: _____

_____

Home #: _____ Pager/Cell#: _____

Work#: _____ Ext: _____ DL#: _____

Employer: _____

Employer's Address: _____

Hw long there? _____ Occupation: _____

Where and when are the best times to reach you?

_____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____

Last Visit Date: _____

Spouse Information

His / Her Name: _____

Employer: _____

Work#: _____ Ext: _____ SSN#: _____

Birthdate: _____ DL#: _____

Dental History

Why have you come to the dentist today? _____

_____

Do you require antibiotics before dental treatment? ☐ YES ☐ NO

Are you currently in pain? ☐ YES ☐ NO

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ YES ☐ NO

Do you have fears about going to the dentist? ☐ YES ☐ NO

Have you ever had gum treatments? ☐ YES ☐ NO

Do you now or have you ever experienced pain/discomfort in your jaw joint? ☐ YES ☐ NO

Do your gums ever bleed? ☐ YES ☐ NO

How many times a week do you floss? _____

How many times a day do you brush? _____

Are you sensitive to heat, cold, or anything else? _____

Have you lost any teeth? ☐ YES ☐ NO If yes, why? _____

_____

Account Responsibility

Primary Person: _____

Work#: _____ Ext: _____ Home#: _____

Billing Address: _____

Relationship: _____ SS#: _____

Employer: _____ DL#: _____

Insurance-Primary

Dental Coverage? ☐ YES ☐ NO

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Subscriber's ID#: _____

Group # (Plan, Local or Policy #): _____

Subscriber's Name: _____ Relation: _____

Subscriber's Birthdate: _____

Subscriber's Employer: _____

Insurance-Secondary

Dental Coverage? YES NO

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID#: _____

Insured's Employer: _____

Employer's Address: _____

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved. This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. 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 hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company. 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 chances in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during Diagnosis and treatment, with my informed consent.

X _____

Medical History Update

I have read my medical history dated _____ and confirmed that it states past and present medical conditions _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions _____
Signature Date