

# PATIENT INFORMATION

## PATIENT INFORMATION (confidential)

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
First Mi Last

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ PROV/STATE \_\_\_\_\_ P.C./ZIP. \_\_\_\_\_

E-MAIL \_\_\_\_\_ CELL PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

SS#/SIN \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

CHECK APPROPRIATE BOX  Minor  Single  Married  Divorced  Widowed  Separated

If College student, F.T. /P.T. Name of School \_\_\_\_\_ City \_\_\_\_\_ Prov./State \_\_\_\_\_

Patient's or parent's/ Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ Prov./State \_\_\_\_\_ P.C./Zip \_\_\_\_\_

Spouse or Parent's/Guardian Name: \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

How did you learn of our practice? \_\_\_\_\_

Person to contact in case of an emergency \_\_\_\_\_

## RESPONSIBLE PARTY

Name of person authorizing for this account \_\_\_\_\_ to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Is this person currently a patient in our office  Yes  No

## INSURANCE INFORMATION

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ Prov/State \_\_\_\_\_ P.C./ZIP \_\_\_\_\_

Insurance Co \_\_\_\_\_ Tel # \_\_\_\_\_ GRP # \_\_\_\_\_ Policy /I.D.# \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ Prov/State \_\_\_\_\_ Prov/State \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max annual benefit \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL INSURANCE  yes  No IF YES, COMPLETE THE FOLLOWING

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS # /SIN \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ Prov/State \_\_\_\_\_ P.C./ZIP \_\_\_\_\_

Insurance Co \_\_\_\_\_ Tel # \_\_\_\_\_ GRP # \_\_\_\_\_ Policy /I.D.# \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ Prov/State \_\_\_\_\_ P.C./ZIP \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max annual benefit \_\_\_\_\_

# PATIENT DENTAL HISTORY

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Reason for this visit \_\_\_\_\_

When was your last dental visit \_\_\_\_\_ What was done then \_\_\_\_\_

How often did you visit the dentist before then \_\_\_\_\_

Previous Dentist ( name and location) \_\_\_\_\_

Have you had a complete series of dental films (x-rays) taken \_\_\_\_\_ When \_\_\_\_\_ Where \_\_\_\_\_

How often do you brush your teeth \_\_\_\_\_ How often do you floss your teeth \_\_\_\_\_

Is your drinking water fluorinated \_\_\_\_\_

Do your gums bleed while brushing or flossing ::  y  n

Are your teeth sensitive to hot or cold liquids/foods ::  y  n

Are your teeth sensitive to Sweet or Sour liquids/ foods ::  y  n

Do you feel pain to any of your teeth ::  y  n

Do you have any sores or lumps in or near your mouth ::  y  n

Have you had any head, neck or jaw injuries ::  y  n

Have you ever experienced any of the following problems in your jaw?

Clicking ::  y  n

Pain (joint, ear, side of face) ::  y  n

Difficulty in opening or closing ::  y  n

Difficulty in chewing ::  y  n

Do you have frequent headaches ::  y  n

Do you bite your lips or cheeks frequently ::  y  n

Have you noticed any loosening of your teeth ::  y  n

Does food tend to become caught between your teeth ::  y  n

Have you ever had periodontal treatment ( gums) ::  y  n

Ever worn a bite plate or other appliance ::  y  n

Have you ever had any difficult extractions in the past ::  y  n

Have you ever had any prolonged bleeding following extractions ::  y  n

Do you wear dentures or partials ::  y  n

If yes, date of placement \_\_\_\_\_

Have you ever received oral hygiene Instructions regarding the care of your teeth and gums ::  y  n

If you could change anything about your smile, what would you change? \_\_\_\_\_

## AUTHORIZATION AND RELEASE

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 practioners. 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 if Guardian is minor

Date \_\_\_\_\_

DOCTOR'S COMMENTS \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

PATIENT NUMBER

# PATIENT MEDICAL HISTORY

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

Although dental personnel primarily treat the area of, and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you are receiving. Thank you for answering the following questions.

- |  |             |   |  |
|--|-------------|---|--|
| 1) Are you in good health ::   | y [ ] n [ ] | 9) Do you bruise easily ::  | y [ ] n [ ]                                  |
| 2) Have there been any changes in your general health within the past year ::                  | y [ ] n [ ] | 10) Have you ever required a blood transfusion ::   | y [ ] n [ ]                                  |
| 3) Date of your last physical exam _____   |             | 11) Have you had a recent weight loss ::  | y [ ] n [ ]                                  |
| 4) Physician's Name _____  |             | 12) Have you ever taken Fen-Phen/Redux ::   | y [ ] n [ ]                                  |
| Address _____  |             | 13) Do you use tobacco ::   | y [ ] n [ ]                                  |
| Phone No: (_____) _____  |             | 14) Do you or have you used controlled substances ::  | y [ ] n [ ]                                  |
| 5) Are you now under the care of a Physician ::  | y [ ] n [ ] | 15) Are you wearing contact lenses ::   | y [ ] n [ ]                                  |
| 6) Have you ever been hospitalized for any surgical operation or serious illness ::            | y [ ] n [ ] | 16) Do you have a persistent cough or throat clearing not associated<br>with a known illness ::             | y [ ] n [ ]<br>(lastings more than 3 months) |
| Please explain _____   |             | 17) Do you have any disease, condition or problem not listed above that<br>you think I should know about :: | y [ ] n [ ]                                  |
| 7) Are you taking any medicine(s), Including non-prescription medicine, I should know about :: | y [ ] n [ ] |   |  |
| If yes, what medicine(s) are you taking _____  |             |   |  |
| 8) Have you had any abnormal bleeding ::   | y [ ] n [ ] |   |  |

## ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

- |  |             |
|--|-------------|
| Local anesthetics like Novocaine ::          | y [ ] n [ ] |
| Penicillin or other antibiotics ::           | y [ ] n [ ] |
| Sulfa Drugs ::                               | y [ ] n [ ] |
| Barbiturates, sedatives or sleeping pills :: | y [ ] n [ ] |
| Aspirin ::                                   | y [ ] n [ ] |
| Iodine ::                                    | y [ ] n [ ] |
| Any metals (eg, Nickel, Mercury, etc) ::     | y [ ] n [ ] |
| Latex / Rubber ::                            | y [ ] n [ ] |
| Other ( Please list) _____                   |             |
| _____  |             |

## ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

- |   |             |
|---|-------------|
| Rheumatic heart disease or rheumatic fever :: | y [ ] n [ ] |
| Scarlet Fever ::                              | y [ ] n [ ] |
| Heart defect or Heart murmur ::               | y [ ] n [ ] |
| Heart trouble, Heart attack, or Angina ::     | y [ ] n [ ] |
| Chest Pain ::                                 | y [ ] n [ ] |
| Shortness of Breath ::                        | y [ ] n [ ] |
| Pacemaker ::                                  | y [ ] n [ ] |
| Heart Surgery ::                              | y [ ] n [ ] |
| High/Low Blood Pressure ::                    | y [ ] n [ ] |
| Congenital heart problem ::                   | y [ ] n [ ] |
| Swelling of feet, ankles, hands ::            | y [ ] n [ ] |
| Hepatitis, Jaundice or Liver disease ::       | y [ ] n [ ] |
| Stroke ::                                     | y [ ] n [ ] |
| Sinus Trouble ::                              | y [ ] n [ ] |
| Lung or breathing problems ::                 | y [ ] n [ ] |
| Asthma or Hay Fever ::                        | y [ ] n [ ] |

## WOMEN ONLY

- |  |             |
|--|-------------|
| Are you pregnant or think you may be pregnant :: | y [ ] n [ ] |
| Are you nursing ::                               | y [ ] n [ ] |
| Are you taking birth control pills ::            | y [ ] n [ ] |

- |                                    |             |
|------------------------------------|-------------|
| Hives or Skin Rash ::              | y [ ] n [ ] |
| Fainting or dizzy spells ::        | y [ ] n [ ] |
| Diabetes ::                        | y [ ] n [ ] |
| AIDS or HIV Infection ::           | y [ ] n [ ] |
| Thyroid Problems ::                | y [ ] n [ ] |
| Allergies ::                       | y [ ] n [ ] |
| Arthritis or Rheumatism ::         | y [ ] n [ ] |
| Joint replacement or implant ::    | y [ ] n [ ] |
| Stomach Ulcer ::                   | y [ ] n [ ] |
| Kidney Trouble ::                  | y [ ] n [ ] |
| Tuberculosis ::                    | y [ ] n [ ] |
| Persistent Cough ::                | y [ ] n [ ] |
| Cough that produces blood ::       | y [ ] n [ ] |
| Chemotherapy (Cancer, Leukemia) :: | y [ ] n [ ] |
| Sexually transmitted disease ::    | y [ ] n [ ] |
| Epilepsy or seizures ::            | y [ ] n [ ] |
| Anemia ::                          | y [ ] n [ ] |
| Glaucoma ::                        | y [ ] n [ ] |
| Nervousness ::                     | y [ ] n [ ] |
| Tonsillitis ::                     | y [ ] n [ ] |
| Tumors ::                          | y [ ] n [ ] |
| Mental Health Care ::              | y [ ] n [ ] |
| Back Problems ::                   | y [ ] n [ ] |
| Chemical Dependency ::             | y [ ] n [ ] |
| Mitral valve prolapse ::           | y [ ] n [ ] |
| Cortisone Treatment ::             | y [ ] n [ ] |
| Cold Sores/ Fever Blisters ::      | y [ ] n [ ] |
| Hypoglycemia ::                    | y [ ] n [ ] |
| Eating disorder ::                 | y [ ] n [ ] |