Patient Information

FULL NAME ______________________________

HOME ADDRESS ______________________________ CITY ______________

STATE ________ ZIP ____________ HOME PHONE ______________________ CELL PHONE ______________

EMPLOYER ______________________ DEPT. __________________ OCCUPATION ______________

WORK PHONE ______________________________ EXT. ____________

BUSINESS ADDRESS ______________________________ ZIP ______________

SOCIAL SECURITY NO. ______________________ DATE OF BIRTH ______________ AGE ________

MARITAL STATUS ______________________________ REFERRED BY ______________

PHONE NUMBER ______________________ EMERGENCY CONTACT ______________

PHYSICIAN ______________________ PREVIOUS DENTIST ______________

DENTAL INSURANCE ______________________ GROUP# ______________

INSURED'S NAME ______________________________

Medical History

Although dental personnel primarily treat the area in 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 will be receiving. Thank you for answering the following questions.

	Yes	No
1. Have you ever been hospitalized, major operations or serious illness?	❑	❑
If so, what? ______________________________		
2. Are you under any medical treatment now?	❑	❑
3. Have you had any allergic reactions to any drugs including penicillin, codeine, novocaine, aspirin?	❑	❑
4. Has there been a change in your health in the past year?	❑	❑
5. Have you ever had a blood transfusion?	❑	❑
6. Have you ever had kidney dyalisis treatment?	❑	❑
7. Have you ever had abnormal bleeding problems after a cut or tooth extraction?	❑	❑
8. Are you now taking drugs or medications?	❑	❑
If so, what? ______________________________		

9. Has a physician ever informed you that you had:

	Yes	No		Yes	No
Heart Ailment	❑	❑	Hepatitis or Yellow Jaundice	❑	❑
High Blood Pressure	❑	❑	Liver Disease	❑	❑
Rheumatic Fever	❑	❑	Venereal Disease	❑	❑
Mitral Valve Prolapse	❑	❑	AIDS	❑	❑
Angina	❑	❑	Stomach or Intestinal Disease	❑	❑
Stroke	❑	❑	Kidney Disease	❑	❑
Blood Disease	❑	❑	Diabetes	❑	❑
Hemophilia	❑	❑	Tuberculosis	❑	❑
Asthma	❑	❑	Respiratory Disease	❑	❑
Epilepsy	❑	❑	Tumors or Growths	❑	❑
Women: A. Are you pregnant?	❑	❑	HIV	❑	❑

B. Estimated Date of Delivery ______________

Dental History

		Yes	No
1.	Please state briefly the reason for your visit. ______		
2.	Do you have discomfort in your mouth now?	☐	☐
3.	How long since your last dental visit? ______		
4.	Were X-rays taken of all teeth at that time?	☐	☐
5.	Do your gums bleed, feel tender or irritated?	☐	☐
6.	Are your teeth sensitive to hot/cold/sweets?	☐	☐
7.	Does food wedge between certain teeth?	☐	☐
8.	Are any teeth loose?	☐	☐
9.	Do you grind, clench or grit your teeth?	☐	☐
10.	Does your jaw ever click or cause pain opening or closing?	☐	☐
11.	Have your front teeth separated creating spaces in them recently?	☐	☐
12.	Have you ever had any teeth extracted?	☐	☐
	If yes, have they ever been replaced to prevent shifting and tipping of remaining teeth and bite collapse?	☐	☐
13.	Did you ever wear braces?	☐	☐
14.	Have you ever worn any dental appliances?	☐	☐
15.	Have you ever had a root canal?	☐	☐
16.	Have you ever had gum treatments?	☐	☐
17.	Do you wear dentures or plates?	☐	☐
	If yes, are you satisfied with your present dentures?	☐	☐
18.	Have you experienced any growths or sore spots in your mouth?	☐	☐
19.	Do you have an unpleasant taste in your mouth?	☐	☐
20.	Do you floss your teeth?	☐	☐
21.	Type of tooth brush ______ hard or soft (circle one)		
22.	Are you aware of or have you been told about having a bad breath problem?	☐	☐

Clinical Examination Summary

Dental History Summary

Medical History Summary

Blood Pressure:

Updating ______

______

______

______

______

CONSENT FOR PROCEDURE

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated and I will assume responsibility for fees associated with those procedures.

Patient's (Parent Signature) ______ Date ______

NOTE: A commensurate fee will be charged for all professional services including consultation.