PATIENT INFORMATION AND HEALTH HISTORY

Patients Name _____ Sex ☐ F ☐ M Date of Birth _____

Address _____ ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

_____ Telephone No. _____ Social Security No. _____

CITY STATE ZIP CODE

Place of Work _____ Telephone No. _____

Person responsible for this account _____ Telephone No. _____

Address _____ Place of Work _____

STREET CITY STATE ZIP CODE

DENTAL HISTORY

Do you have or have you had any of the following – indicate with a (✓)

☐ Pain at this time
☐ Teeth sensitive to cold, heat, sweets or pressure
☐ Bleeding gums – How long _____
☐ Food impaction
☐ Clenching or grinding
☐ Burning of tongue
☐ Swelling or lumps in mouth
☐ Frequent blisters on lips or mouth
☐ Pain around ear, joint, side of face
☐ Change in your bite
☐ Clicking of the jaw
☐ Difficulty opening or closing
☐ Bad breath
☐ Unpleasant taste
☐ Complications from extractions
☐ Periodontal treatment
☐ Oral Surgery
☐ Orthodontic Treatment
☐ Cigarette, pipe, cigar or chewing tobacco
☐ Oral habits, i.e., fingernail biting, cheek biting, etc.
☐ Loose or separating teeth
☐ Red, swollen or tender gums
☐ Worn a bite splint
☐ Bite adjusted

DATE OF LAST DENTAL VISIT	DATE OF LAST CLEANING	DATE OF LAST FULL MOUTH SERIES OF X-RAYS

MEDICAL HISTORY

Physicians Name _____ Telephone No. _____ Date of last physical exam _____

Do you have or have you had any of the following – indicate with a (✓)

☐ Any heart ailments/heart murmur
☐ Do you need to be pre-medicated
☐ Rheumatic fever
☐ Allergies to drugs
☐ Allergies to anesthetics
☐ HIV positive
☐ Sexually transmitted disease
☐ High blood pressure
☐ Low blood pressure
☐ Excessive bleeding from a cut or extraction
☐ Hay fever or allergies in general
☐ Psychiatric care/emotional problems
☐ Artificial joints/prosthesis
☐ Neurological problems
☐ Radiation treatments
☐ Anemia or blood problems
☐ Asthma
☐ Kidney problems
☐ Malignancies
☐ Sinus problems
☐ Venereal disease
☐ Liver problems or hepatitis
☐ Seizure disorder
☐ Arthritis
☐ Diabetes
☐ Stroke
☐ Thyroid
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcer or colitis
☐ Eye disorders
☐ Pregnancy/Month _____
☐ Birth Control pills

Describe any current or past medical treatment _____

_____

Medications _____

DENTAL INSURANCE INFORMATION

PRIMARY CARRIER

Insured's Name _____ Telephone No. _____ Date of Birth _____

Insurance Co. _____ Address _____

Insured's Employer _____ Address _____

Insured's Soc. Sec. # _____ Group # _____

SECONDARY CARRIER

Insured's Name _____ Telephone No. _____ Date of Birth _____

Insurance Co. _____ Address _____

Insured's Employer _____ Address _____

Insured's Soc. Sec. # _____ Group # _____

Whom may we thank for referring you to our office? _____

ABOVE INFORMATION IS TRUE Signature _____ Date _____

(PARENT OR GUARDIAN IF PATIENT IS A MINOR)