



PATIENT MEDICAL HISTORY

Patient Name: _____
 Physician's Name: _____ Last Visit: _____
 Phone: _____
 Are you currently under the care of a doctor? Yes No
 Explain: _____
 Please list all drugs patient is taking:

FOR WOMEN ONLY

Are you taking birth control pills? Yes No
 Are you pregnant? Yes No Weeks #: _____
 Are you nursing? Yes No

HAS THE PATIENT EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Abnormal Bleeding	Yes	No	Sinus Problems	Yes	No	Are you allergic to any of the following? Latex Yes No Nickel Yes No Aspirin Yes No Tylenol Yes No Ibuprofen Yes No Codeine Yes No Penicillin Yes No Other: Yes No
HIV+/AIDS	Yes	No	Difficulty Breathing	Yes	No	
Hemophilia	Yes	No	Convulsions/Epilepsy	Yes	No	
Hi/Lo blood pressure	Yes	No	Diabetes	Yes	No	
Blood Transfusion	Yes	No	Kidney/Liver Problems	Yes	No	
Cancer	Yes	No	Hepatitis	Yes	No	
Anemia/Radiation tmt.	Yes	No	Artificial bones/joints	Yes	No	
Heart attack	Yes	No	Fever blister	Yes	No	
Artificial Cardiac Valve	Yes	No	Venereal disease	Yes	No	
Congenital Heart Disease	Yes	No	Drug/Alcohol Abuse	Yes	No	
Infective Endocarditis	Yes	No	Osteoporosis	Yes	No	
Heart Murmur	Yes	No	Psychological Problems	Yes	No	
Asthma	Yes	No	Any Stays in Hospital	Yes	No	
Tuberculosis	Yes	No	Other:			

PATIENT DENTAL HISTORY

- Have you ever had a bad dental experience? Yes No
- Do your gums bleed or ever feel sore? Yes No
- Have you ever had any dental treatment to your gums? Yes No
- Do you have frequent or chronic headaches? Yes No
- Do your jaws ever click or pop when chewing or opening? Yes No
- Have you ever had difficulty in opening or closing your jaw? Yes No
- Do you clench your teeth during the day or grind your teeth at night? Yes No
- Do you ever have earaches, ringing in the ears or feel dizzy? Yes No

AGREEMENT

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need during treatment.

Signature of Parent/Patient/Guardian

Date

► **WHAT WOULD YOU LIKE TO CHANGE THE MOST IN THE APPEARANCE OF YOUR TEETH?** _____

FOR OFFICE USE ONLY

Date: _____ Date: _____
 Reviewed by: _____ Reviewed by: _____
 Doctor's Notes: _____ Doctor's Notes: _____

GENERAL PATIENT INFORMATION

Patient Name: _____ Gender: _____ Birthdate: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Responsible Party: _____ Relationship to Patient: _____

Address for Statements (if different from above): _____

City: _____ State: _____ Zip: _____

E-mail (for appointment reminders): _____

Has any family member been a patient here? _____ Name: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

DENTIST: _____ When was the last time you visited a dentist office? _____

How have you heard of our office? Please check all that apply FRIEND FRIEND'S NAME: _____

- YELLOW PAGES YOUR DENTIST FAMILY MEMBER NEWSPAPER DIRECT MAIL INTERNET
 TELEVISION PREVIOUS PATIENT INSURANCE PLAN SCHOOL STAFF MEMBER OTHER

IF PATIENT IS AN ADULT:

Employer: _____ Spouse: _____

Address: _____ Employer: _____

Position: _____ Address: _____

Phone Number: _____ Phone Number: _____

Social Security #: _____ Social Security #: _____

Drivers License #: _____ Drivers License #: _____

IF PATIENT IS A CHILD:

Father: _____ Mother: _____

Employer: _____ Employer: _____

Position: _____ Position: _____

Work Phone #: _____ Work Phone #: _____

Social Security #: _____ Social Security #: _____

SIBLINGS: Name: _____ Age: _____ Name: _____ Age: _____

MARITAL STATUS: Married Separated Divorced Widowed

ORTHODONTIC INSURANCE INFORMATION:

PRIMARY INSURANCE

Policy Holder: _____

Birthdate: _____ Employer: _____

Insurance Company: _____

Insurance Phone: _____

Address: _____

Policy / Group #: _____

Employee ID #: _____

SECONDARY INSURANCE

Policy Holder: _____

Birthdate: _____ Employer: _____

Insurance Company: _____

Insurance Phone: _____

Address: _____

Policy / Group #: _____

Employee ID #: _____