PATIENT INFORMATION AND HEALTH HISTORY

INITIAL EXAM

DATE ____________

PATIENT'S NAME ____________
CIRCLE ONE - SINGLE MARRIED DIVORCED SEPARATED WIDOWED

DATE OF BIRTH ____________

PATIENT'S ADDRESS ____________

PATIENT'S PHONE ____________

PERSON RESPONSIBLE FOR THIS ACCOUNT ____________

BUSINESS PHONE ____________

EMPLOYED BY ____________ Cell Phone ____________

BUSINESS ADDRESS ____________

PATIENT'S SS # ____________

IF MINOR PARENT'S SS # ____________

DENTAL INSURANCE PLAN (IF ANY) ____________

REFERRED BY ____________

SECONDARY DENTAL INSURANCE ____________
INCLUDE COMPANY, PERSON INSURED, GROUP #, SS #, DATE OF BIRTH

DENTAL HISTORY

Email ____________

CHIEF ORAL COMPLAINT ____________

DATE OF LAST DENTAL EXAM ____________ ANY PREVIOUS MAJOR DENTAL TREATMENT, ❑ YES ❑ NO
IF YES, WHEN ____________

- ❑ 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
- ❑ Unusual sounds in ear while eating
- ❑ Bad breath
- ❑ Unpleasant taste
- ❑ Unfavorable dental experience
- ❑ Complications from extractions
- ❑ Periodontal treatment
- ❑ Orthodontic treatment
- ❑ Mouth breathing
- ❑ Oral habits, i.e., fingernail biting, cheek biting, etc.
- ❑ Cigarettes, pipe or cigar smoking
- ❑ Chewing Tobacco
- ❑ Texture of toothbrush ______
- ❑ Frequency of brushing ______
- ❑ Dental floss
- ❑ Inter dental stimulators
- ❑ Water jet device
- ❑ Disclosing tablets or solution
- ❑ Fluoride supplements

MEDICAL HISTORY

PHYSICIAN'S NAME ____________ DATE OF LAST PHYSICAL EXAM ____________ AGE ______

PHONE # ____________ DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING - INDICATE WITH A CHECK MARK

- ❑ Allergies to drugs ______
- ❑ Allergies to anesthetics ______
- ❑ Any heart ailments
- ❑ High blood pressure
- ❑ Neurological problems
- ❑ Radiation treatments
- ❑ Excessive bleeding from cut or extraction
- ❑ Anemia or blood problems
- ❑ Arthritis
- ❑ Joint replacement
- ❑ Cold Sores
- ❑ Asthma
- ❑ May fever or allergies in general
- ❑ Diabetes
- ❑ Kidney problems
- ❑ Liver problems or hepatitis
- ❑ Malignancies
- ❑ Psychiatric care/emotional problems
- ❑ Rheumatic fever
- ❑ Sinus problems
- ❑ Aids or HIV infection
- ❑ Stroke
- ❑ Thyroid
- ❑ Eye disorder/glaucoma
- ❑ Tonsilitis
- ❑ Tuberculosis
- ❑ Ulcer or colitis
- ❑ Current pregnancy
  If so, what month ______
- ❑ Venereal disease
- ❑ Lyme disease

Describe any current medical treatment including drugs taken, even though not listed above ____________

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. This fee covers only portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

SIGNATURE ____________ DATE ____________
(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)