

Patient Information

Patient Name _____ Social security # _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Patient Employer _____ Age _____ D.O.B. _____ Marital Status _____ Driver's Lic# _____

Bus # _____ Mobile # _____ Pager # _____ E-mail _____

Name and # of emergency contact person _____ Relationship _____

How did you find out about our office? _____

Insurance Information (please fill out completely)

Person responsible for account _____ Relationship to patient _____

Address (if different) _____ City _____ State _____ Zip _____

Home # _____ Bus # _____ Mobile # _____ Driver's Lic# _____

Birthdate _____ Social Security # _____ Subscriber Employer _____

Insurance Company _____ Group # _____ Phone # _____

Insurance Company Address _____

Dental History

Last Dental Visit _____ Past major dental treatment _____

How often do you brush? _____ How often do you floss? _____

What did you like most about your former dental office? _____

What do you like least about going to the dentist? _____

Please place a check mark next to any dental problem that you are experiencing.

Bleeding Gums

Grinding Teeth

Sensitivity to Hot

Sores in Mouth

Jaw Pain

Sensitivity to Cold

Bad Breath

Broken Fillings

Sensitivity to Biting

Receding Gums

Loose Teeth

Sensitivity to Sweets

Do you like your smile? _____ Would you like whiter teeth? _____ Are you interested in a cosmetic consultation? _____

If you had a magic wand, what would you change about your smile/teeth? _____

Medical History

Patient Name _____ Date _____

Medical Doctor's Name _____ Phone # _____

Please describe any serious illness or any operations you have or have had _____

Please place a check mark next to any condition below that you have now or have *ever* had in the past.

<input type="checkbox"/> AIDS	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cortisone Treatment	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Fainting	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tobacco Habit
	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> Venereal Disease

Please place a check mark next to any condition that you *currently* have.

<input type="checkbox"/> <u>Cardiovascular Disease</u>	<input type="checkbox"/> <u>Respiratory Disease</u>	<input type="checkbox"/> <u>Gastrointestinal Disease</u>
<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> Cough	<input type="checkbox"/> Sudden Weight Loss or Gain
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Phlegm	<input type="checkbox"/> Change in Appetite
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Cough up Blood	<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Edema (swelling of legs or ankles)	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Change in Bowel Habits
<input type="checkbox"/> Tiredness	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Unexplained Vomiting
<input type="checkbox"/> <u>Genitourinary Disease</u>	<input type="checkbox"/> <u>Neurological Disease</u>	<input type="checkbox"/> <u>Musculoskeletal Disease</u>
<input type="checkbox"/> Pain During Urination	<input type="checkbox"/> Headaches	<input type="checkbox"/> Pain in Joints
<input type="checkbox"/> Frequent Nighttime Urination	<input type="checkbox"/> Seizures	<input type="checkbox"/> Artificial Joints
<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Visual Disturbances	<input type="checkbox"/> Swelling in Joints
<input type="checkbox"/> Constant feeling of Urination	<input type="checkbox"/> Weakness/Tingling/Numbness	<input type="checkbox"/> Arthritis
	<input type="checkbox"/> Difficulty in Urination	<input type="checkbox"/> Loss of Coordination

Do you have any allergies to any medications? ___ If so, which ones? _____

Does skin react to any type of jewelry, metals or latex? _____

Explain your allergic reaction to these medications. _____

Please list any medications that you are currently taking and for what conditions, including over-the-counter drugs, and the dosage if known _____

Do you have any other medical condition that has not been covered above? _____ If so, please discuss with the doctor.

The medical history described above is complete to the best of my knowledge.

Signature of Patient or Guardian _____ Date _____