

Patient Name:

Account #:

Patient Code:

Date:

Patient, Pharmacy and Insurance Information

Patient Information

Prefix: _____ First Name: _____ Middle Name: _____ Last Name: _____

Suffix: _____

Street: _____ Zip: _____ City: _____ State: _____ Country: _____

Preferred Phone #: _____ Is this a mobile number? Yes No

Email Address: _____

Date of Birth: _____ Sex: Male Female Unspecified

Emergency Contact: _____ Emergency Phone #: _____

Primary Language: English Spanish Other: _____

Responsible Party

First Name: _____ Middle Name: _____ Last Name: _____

Street: _____ Zip: _____ City: _____ State: _____ Country: _____

Date of Birth: _____ Sex: Female Male Unspecified

Responsible Party Signature: _____ Date: _____

Preferred Pharmacy

Name: _____ Phone Number: _____

Street: _____ Zip: _____ City: _____ State: _____

Primary Dental Insurance

Is subscriber the same as patient? Yes No

Subscriber Information:

First Name: _____ Middle Name: _____ Last Name: _____

Employer Name: _____ Insurance Company: _____

Ins Phone Number: _____

Subscriber ID/Policy Number: _____ Group/Contract Number: _____ Date of Birth: _____

Patient Relationship to Subscriber: Child Disabled Dependent Husband Self Wife Other Dependent

Subscriber SSN: _____

Secondary Dental Insurance

Is subscriber the same as patient? Yes No

Subscriber Information:

First Name: _____ Middle Name: _____ Last Name: _____

Employer Name: _____ Insurance Company: _____

Ins Phone Number: _____

Subscriber ID/Policy Number: _____ Group/Contract Number: _____ Date of Birth: _____

Patient Relationship to Subscriber: Child Disabled Dependent Husband Self Wife Other Dependent

Subscriber SSN: _____

Patient Name:

Account #:

Patient Code:

Date:

Health History

Reason for Visit: Broken Tooth Check-up Cosmetic Dentures Tooth Pain Other: _____

Height: _____ ft _____ in Weight: _____ Patient Date of Birth: _____

Are you under the care of a primary physician? Yes No

Primary Physician's Name: _____ Physician's Phone Number: _____

Date of Last Physical:

I don't know exact date Last 6 months 6 months - 1 year 1-3 years Greater than 4 years Never Other: _____

Are you taking or have you taken any steroid/cortisone therapy in the last 2 years? Yes No

Have you ever been hospitalized? Yes No

Are you taking or have you taken Oral Bisphosphonates (e.g., FOSAMAX, BONIVA) or IV Bisphosphonates, (e.g., ZOMETA, AREDIA)?

No Yes How Long? _____

Do you require antibiotics prior to dental procedures? Yes No

Are you allergic or have you had an adverse reaction to any of the following?

None Amoxicillin Aspirin Codeine Epinephrine Latex Metals Novocain Penicillin Sulfa Tetracycline

Other: _____

List any medications you are taking including non-prescription drugs and herbals/vitamins:

None

Check any conditions that apply to you:

None

Alcoholism

Allergies or Hives

Anemia

Arthritis

Artificial Joint/Pins

Type: _____

Age: _____

Aspirin Therapy

Asthma

Blood Thinners

Blood Transfusion

Breathing Problems

Cancer

Type: _____

Chemotherapy

Coumadin Therapy

Dementia

Diabetes

Type: _____

Dialysis

Drug Addiction

Epilepsy

Excessive Bleeding

Fainting/Dizziness

Hearing Impairment

Heart Murmur

Heart Surgery

Date: _____

Heart Trouble

Type: _____

Hepatitis

Type: _____

High Blood Pressure

HIV

Kidney Disease

Liver Disease

Low Blood Pressure

Lung Disease/COPD

Lupus

Mitral Valve Prolapse

Mobility Impairment

NON-DENTAL Implants

Type: _____

Organ Transplants

Type: _____

Pace Maker

Psychiatric Care

Radiation Therapy

Radiosurgery

Rheumatic Fever

Seizures

Sexually Transmitted Disease

Sinus Problems

Stomach Problems

Stroke

Thyroid Disease

Tuberculosis(TB)

Ulcers

Visual Impairment

Other Disease/Illness

Type: _____

Patient Name:

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Dental History

Date of Last Dental Visit:

I don't know exact date Last 6 months 6 months - 1 year 1-3 years Greater than 4 years Never Other: _____

Date of Last Dental X-ray:

I don't know exact date Last 6 months 6 months - 1 year 1-3 years Greater than 4 years Never Other: _____

Oral Health

Have you ever been treated for periodontal (gum) disease? Yes No

Have you ever had Novocaine or other local anesthetic? Yes No

How happy are you with your smile (1-10)? _____

Are you currently wearing Dentures? Yes No

Age of dentures: Less Than 6 Months 6 months-3 years Greater than 4 years

Please check any conditions that apply to you below:

- Pain In Jaw(TMJ) Teeth Grinding/Clenching Use Tobacco Products Mouth Sores
- Sensitive Teeth Broken/Loose Teeth Difficulty Chewing/Swallowing Swollen/Bleeding Gums

Women Patients Only

Are you currently pregnant? Yes No Estimated Delivery Date: _____

Are you Nursing? Yes No Are you taking any birth control prescriptions? Yes No

**NOTE Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature: _____ Date: _____

Dr's Signature/Medical History Review: _____ Date: _____

6 MONTH UPDATE

Patient's Signature: _____ Date: _____

Dr's Signature/Medical History Review: _____ Date: _____