PATIENT HISTORY AND INFORMATION

(CONFIDENTAL INFORMATION FOR OUR FILES)

Cell Phone # _____

Email _____

Driver's license No:_____

Patients Soc. Sec. No_____

NAME_____ BIRTH DATE _____GENDER_____

LAST MR. MRS. MISS. FIRST

RES. ADDRESS_____ RES. PHONE _____

STREET CITY STATE ZIP

EMPLOYED BY _____ OCCUPATION _____

REFERRED BY _____ PHYSICIAN _____

PHARMACY NAME _____ PHARMACY PHONE _____

DENTAL INSURANCE_____ GROUP/PLAN NO. _____

INSURED'S SOC. SEC. NO. _____ INSURED'S BIRTH DATE _____

ANSWER ALL QUESTIONS – YOU MAY COMMENT ON ANSWERS REQUIRING EXPLANATION AT BOTTOM

1. When was your last visit to a dentist? ..... yes.....no
2. Is there anything you would change with your smile? ..... yes.....no
3. Are you being treated by a physician for any condition now? ..... yes.....no
4. Does your jaw click when you chew? ..... yes.....no
5. Is it difficult for you to open your mouth as wide as you would like? ..... yes.....no
6. Do you have fainting spells? ..... yes.....no
7. Women, are you pregnant or nursing? ..... yes.....no
8. Have you ever had any of the following
   - Hepatitis/Yellow Jaundice ..... yes.....no
   - AIDS/HIV Positive..... yes.....no
   - Tuberculosis ..... yes.....no
   - Sexually Transmitted Diseases ..... yes.....no
9. Do you use tobacco products? ..... yes.....no

Are you allergic to any of the following?

Penicillin.....	yes.....no	Barbiturates.....	yes.....no
Codeine.....	yes.....no	Any Metals.....	yes.....no
Erythromycin.....	yes.....no	Sulfa Drugs.....	yes.....no
Tylenol	yes.....no	Latex.....	yes.....no
Aspirin	yes.....no	Ibuprofen.....	yes.....no
Dental Anesthetic	yes.....no	Clindamycin.....	yes.....no
Iodine	yes.....no	Other.....	yes.....no
Sulfites (food preservation)	yes.....no		

Have you ever had any of the following?

Rheumatic Fever	yes.....no	High Blood Pressure	yes..... no
Heart Murmur	yes.....no	Dialysis Shunt	yes..... no
Heart Valve	yes.....no	Stroke	yes..... no
Congenital Heart Defect	yes.....no	Diabetes	yes..... no
Mitral Valve Prolapse	yes.....no	Thyroid Trouble	yes..... no
Pacemaker	yes.....no	Liver Trouble/Cirrhosis	yes..... no
Angina	yes.....no	Blood Disorders	yes..... no
Heart Attack	yes.....no	Glaucoma	yes.....no
Open Heart Surgery	yes.....no	Epilepsy	yes.....no
Bypass Surgery	yes.....no	Asthma	yes.....no
Coronary Angioplasty	yes.....no	Respiratory Problems	yes.....no
Prosthetic Joint	yes.....no	Chemical/Alcohol Dependency .	yes.....no
Cancer/Radiation Therapy	yes.....no	Muscular Dystrophy	yes.....no

Other Health Problems? Please Explain: _____

List any medications you are currently taking and reason for taking:_____

_____

PAYMENT IS REQUIRED WHEN SERVICES ARE RENDERED, UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. PLEASE GIVE US 24 HOURS NOTICE IN CANCELLING AN APPOINTMENT OR A FEE OF $50.00 MAY BE ASSESSED TO YOUR ACCOUNT. THANK YOU

SIGN_____ **DATE** _____