PATIENT INFORMATION AND MEDICAL HISTORY

DATE_____ HOME PHONE _____CELL PHONE_____

EMAIL ADDRESS_____

PATIENT_____
LAST NAME FIRST NAME INITIAL PREFERRED NAME

STREET ADDRESS _____CITY_____ STATE_____ ZIP_____

SOCIAL SECURITY NUMBER_____ DRIVER'S LICENSE NUMBER_____

SEX ☐M ☐F AGE_____ BIRTHDATE_____ ☐ SINGLE ☐MARRIED ☐WIDOWED ☐SEPARATED ☐DIVORCED

EMPLOYED BY_____ OCCUPATION_____BUSINESS PHONE_____

SPOUSE'S NAME_____ SPOUSE'S SOCIALSECURITY_____

SPOUSE'S EMPLOYER _____ OCCUPATION_____BUSINESS PHONE_____

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT_____

NAME OF DENTAL INSURANCE COMPANY _____ GROUP NUMBER_____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED_____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU _____

DENTAL HISTORY

CHIEF ORAL COMPLAINT_____

DATE OF LAST EXAM_____ DATE OF LAST CLEANING_____

HAVE YOU HAD FULL MOUTH X-RAYS TAKEN _____ IF YES, WHEN_____

HAVE YOU HAD OR ARE YOU CURRENTLY UNDERGOING ANY OF THE FOLLOWING:

☐PERIODONTAL TREATMENT ☐ORTHODONTIC TREATMENT ☐COMPLICATIONS FROM EXTRACTIONS

☐UNFAVORABLE DENTAL EXPERIENCE ☐REACTION TO ANESTHETIC

MEDICAL HISTORY

PHYSICIAN'S NAME_____ ADDRESS_____

DATE OF LAST PHYSICAL EXAM _____

HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING:

☐HIGH BLOOD PRESSURE	☐EXCESSIVE BLEEDING	☐ARTHRITIS	☐ ARTIFICAL JOINTS/PINS/RODS	☐HEPATITIS TYPE_____
☐HEART MURMUR	☐RESPIRATORY DISEASE	☐ULCER	☐CHEMICAL DEPENDENCY	☐YELLOW JAUNDICE
☐PACEMAKER	☐VENEREAL DISEASE	☐ ASTHMA	☐ IMMUNOSUPRESSIVE DISORDER	☐RHEUMATIC FEVER
☐ARTIFICIAL HEART VALVES	☐SINUS PROBLEMS	☐STROKE	☐DIABETES TYPE_____	☐TUBERCULOSIS
☐HEART ATTACK	☐SMOKER/TOBACCO USE	☐HIV/AIDS	☐RADIATION TREATMENT	☐SEIZURES/EPILEPSY
☐OTHER HEART PROBLEMS				

DO YOU HAVE ANY DRUG ALLERGIES OR HAVE YOU EVER HAD AN ADVERSE REACTION TO ANY MEDICATIONS? _____

IF SO, WHAT? _____

ARE YOU TAKING ANY MEDICATION AT THIS TIME? _____ IF SO WHAT? _____

_____

_____

PLEASE TURN PAGE OVER

HAVE YOU EVER TAKEN ANY BISPHOSPHONATES (FOSAMAX, BONIVA, ACTONEL ,PROLIA, Etc.)?_____

HAVE YOU BEEN HOSPITALIZED IN THE LAST 5 YEARS? _____ IF SO, FOR WHAT? _____

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? _____IF SO, FOR WHAT CONDITION? _____

(WOMEN) ARE YOU PREGNANT? _____ DUE DATE _____ARE YOU CURRENTLY TAKING BIRTH CONTROL PILLS? _____

IS THERE ANYTHING ELSE WE SHOULD BE AWARE OF CONCERNING YOUR PHYSICAL HEALTH? _____

_____

APPOINTMENTS: When an appointment has been made for you at our office, please remember that this time is reserved for you. If it is necessary to reschedule your appointment, please call at least **24 hours prior to appointment time.**

OFFICE CHARGES ARE PAYABLE AT THE TIME OF SERVICE. BALANCES OVER 90 DAYS WILL BE SUBJECT TO A 10 % A.P.Y. FINANCE CHARGE. Our staff will assist you, our patient, in filing necessary forms to obtain benefits from your insurance company for our professional services rendered. We do not render our services on the basis that insurance companies will pay all of our fees. Each fee is individual for the individual patient and fees for services rendered are the patient's personal responsibility.

_____ _____

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

_____ _____

SIGNATURE OF DENTIST DATE

FOR OFFICE USE ONLY

MEDICAL HISTORY UPDATE

Have there been any changes in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what_____

_____ _____

Date Signature

MEDICAL HISTORY UPDATE

Have there been any changes in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what_____

_____ _____

Date Signature

MEDICAL HISTORY UPDATE

Have there been any changes in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what_____

_____ _____

Date Signature