PATIENT INFORMATION

Date ______________________________

Name: Last____________________________First __________________________________ MI________

Address : Street______________________________ City ____________________ State___ Zip________

Home Phone ____________________________ Cell Phone ______________________________________

Business Phone ___________________________ E-mail Address _________________________________

Birth Date ______________________________ Social Security #__________________________________

Business Name / Address ____

Hobbies and Interests (optional) ____

Whom may we thank for referring you to our office? Please check all that apply:

Friend/Family/Doctor ____ Internet _____ Yellow Pages ______

FAMILY INFORMATION

HUSBAND (Father if a minor)	**WIFE** (Mother if a minor)
Name ____________________________________	Name ____________________________________
Address____________________________________	Address ___________________________________
City/State__________________________________	City/State __________________________________
Telephone __________________________________	Telephone ______________________________
Birth Date/SSN ____________________________	Birth Date/ SSN ____________________________
Employer __________________________________	Employer __________________________________

PERSON RESPONSIBLE FOR ACCOUNT: Please circle one: Patient/Father/Husband/Mother/Wife/Guardian

PERSON TO CONTACT IN CASE OF EMERGENCY	Name ____
	Home Phone ________________________ Cell __________________________

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary, with my permission (patient) for proper dental care.

I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another doctor.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claim for insurance benefits.

If you would like our assistance in obtaining your insurance benefits, please furnish your insurance card or information.

I attest to the accuracy of the information provided on this page.

SIGNATURE OF RESPONSIBLE PARTY ____ **DATE** __________________

MEDICAL HISTORY

Patient Name: ____ Date: ________________________________

Presently under a physicians care? Yes /No Date of last physical exam: ____________________________

Physician's Name: _____________________________________ Phone: _______________________________

DO YOU HAVE ANY OF THE FOLLOWING?

Please indicate those which apply by **circling**, and those which do not apply by a **slash.**

Hospitalization/Surgery

Rheumatic Fever

Heart Murmur

Mitral Valve Prolapse

Prosthetic (artificial) Heart Valve/Artificial Joints

Bleeding Tendency

High Blood Pressure (Yourself/Family)

Breathing Problems/Asthma

Anemia

Diabetes (Yourself/Family)

Blood thinners/Coumadin/Aspirin

History of Phen-Fen (Ionamn-phentermine, Pondimin-fenfluramine)

Taking Medications/Drugs/ Natural Remedies:

Please List Medications or Furnish a Copy:

____

____

Hepatitis (Yourself/Family)

Infectious Diseases (Yourself/Family)

Systemic Lupus Erythematosus

Ulcers

Arthritis

Cancer

Leukemia/Multiple Myeloma/Lymphoma

Seizures/Stroke

Psychiatric Care

Sinus Problems

Thyroid Problems

Use of Tobacco

Use of Alcohol

Pregnant/Breast Feeding

Last Menstrual Period Date ___________________

Allergies to Drugs or Medications: ______________________

Do you have problems or conditions not listed above? Yes ____________________________________ No _______

Do you wish to discuss anything with the doctor in private? Yes ____________________________________ No _______

I understand the importance of a truthful health history and I realize that incomplete information may have an adverse effect on my health.

Signature of Patient or Guardian ____________________________________ Date ______________________

Signature of Witness ____ Date ______________________

DENTAL HISTORY

Patient name: ____ Date: ___________________________________

Date of last dental examination: __________________________ Date of last dental cleaning: __________________________

How many times a year do you have you teeth cleaned? (Circle one) 1 2 3 4

How many times a year has it been recommended by your previous dentist that

you have your teeth cleaned? (Circle one) 1 2 3 4

How many times do you brush daily? (Circle one) 1 2 3 4

How often do you floss? (Circle one) Daily Weekly Sometimes Never

DO YOU HAVE ANY OF THE FOLLOWING?

Please indicate those that **apply to you by circling**, indicate those that **do not apply to you by slashing** through the item.

Bleeding Gums	Toothache
Receding Gums	Clench or Grind Your Teeth
Gag Easily	Difficulty Chewing Food
Bad Taste/Odor in Mouth	Difficulty Chewing Food
Previous Gum (Periodontal) Treatment	Jaw muscles tired at the end of the day/morning
Teeth Loose	Upon opening your mouth, clicking/grating noise?
Mouth Sores/Herpes	

Do you feel any limitation when opening your mouth? Yes _______ No ________

Ever had trauma to the face/head? Yes _______ No ________

Do you wear full/partial dentures? Upper ______ Yes _______ No ________ How long? ___________________

Lower ______ Yes _______ No ________ How Long? __________________

Do you have problems with your full/partial dentures? Yes _______ No ________

Would you like to change the appearance of your teeth? Yes _______ No ________

What is the purpose of today's visit? ____

____

Signature of Patient or Guardian ______________________________________ Date _______________________________

Signature of Witness ____ Date _______________________________