PATIENT INFORMATION AND HISTORY

INITIAL EXAM DATE_____

PATIENT'S NAME_____ DATE OF BIRTH_____/_____/_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPERATED ☐ WIDOWED

PATIENT'S ADDRESS_____ PATIENT'S SS#_____-_____-_____

CITY_____ STATE_____ ZIP CODE_____ HOME PHONE (_____)_____-_____

PERSON RESPONSIBLE FOR THIS ACCOUNT_____

ADDRESS_____ HOME PHONE (_____)_____-_____

CITY_____ STATE_____ ZIP CODE_____

EMPLOYED BY_____ BUSINESS ADDRESS _____

BUSINESS PHONE (_____)_____-_____ RESPONSIBLE PARTY'S SS#_____-_____-_____

RESPONSIBLE PARTY'S D.O.B._____/_____/_____ REFERRED BY _____

DENTAL INSURANCE PLAN (IF ANY)_____

DENTAL HISTORY

CHIEF ORAL COMPLAINT _____

DATE OF LAST DENTAL EXAM_____ ANY PREVIOUS DENTAL TREATMENT: ☐ YES ☐ NO WHEN?_____

INSTRUCTIONS:

To receive treatment in this office you must answer all questions on this history form.

The questions asked relate directly to the safe and effective treatment you are to receive in the office-to the best of your ability, honest answers must be given.

If you are unsure of the question, unsure of your answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor.

Some of the questions may not relate to you or your medical condition; in that event you are to write "N/A" (not applicable) in the space provided.

All questions must be answered.

To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is "Permission to Release Information." You are asked to sign it in the presence of a member of the office staff.

1. Name, address & telephone # of your physician _____

_____

2. Date of last visit to your doctor _____ Purpose of visit _____
3. Do you suffer from any disability?_____ If yes, describe_____

_____

4. Have you ever, or do you now take illegal drugs? _____ If yes, what drugs, and when taken? _____

_____

Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.

5. Do you have AIDS, or are you HIV-positive? _____ If yes, describe and provide current status. _____
6. Do you now have, or have you ever had a venereal disease? _____ If yes, describe _____
7. Have you ever had, or do you now have hepatitis? _____ If yes, describe. _____
8. For females: Are you pregnant? _____ If yes, when are you due? _____
9. For females: Are you taking birth control pills? _____

Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.

10. Are you taking any drugs or medications? _____ If yes, list and describe amounts and purpose. _____

_____

Note: There are many drug and medication incompatibilities, some of which may result in dangerous health problems. Information about your current use of drugs and medication is essential.

11. Have you ever had an allergic reaction to medication? _____ If yes, describe. _____
12. Have you lost weight recently? _____ If yes, describe. _____

HAVE YOU EVER HAD OR BEEN TREATED FOR:

13. Rheumatic fever, rheumatic heart disease, heart murmur, or congenital heart disease? _____
14. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? _____
15. Stomach or intestinal disease? _____
16. Abnormal blood pressure, excessive bleeding, or anemia? _____
17. Breathing problems, asthma, tuberculosis, or hay fever? _____
18. Cancer, X-ray treatments, or chemotherapy? _____
19. Diabetes? _____
20. Kidney problems or renal dialysis? _____
21. A stroke, convulsions, or fainting spells? _____
22. Tumors or growths? _____
23. Arthritis or rheumatism? _____
24. Have you ever had a major operation? _____ If yes, describe. _____
25. Have you ever had a serious injury to your head or neck? _____ If yes, describe. _____
26. Are you on a special diet? _____ If yes, for what reason and describe. _____
27. Do you smoke? _____ If yes, describe type and quantity. _____
28. Have you consulted or been treated by a psychiatrist, psychologist, or counselor? _____ If yes, describe. _____
29. Are there any other problems about your health of which you are aware? _____

_____

DENTAL HISTORY

Date and reason for your last visit to a dentist _____

Do you have any of your x-rays or dental records? _____

In respect to any previous dental treatment have you:

30. Ever fainted? _____
31. Had an allergic reaction? _____
32. Had abnormal bleeding? _____
33. Any other complications during or following dental treatment? _____ If yes, describe. _____
34. Do your gums bleed on brushing or eating? _____
35. Does food catch between your teeth? _____
36. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose? _____
37. Are any of your teeth sensitive to heat, cold, or pressure? _____
38. Do you grind your teeth or clench your jaws? _____
39. Do you have pain or clicking in the jaw joint around your ear? _____
40. Have your jaw muscles ever been sore? _____ If yes, describe. _____
41. Are there any sores or growths in your mouth? _____
42. Do any of your teeth ache? _____
43. Do you have any other dental complaint? _____

_____

APPOINTMENTS: A minimum charge will be made for failed or canceled appointment without prior notification of 24 hours. This fee covers only a portion of overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

NOTE: A change in your health status should be reported to the office at the earliest possible time.

To the best of my knowledge, the foregoing questions have been accurately answered.

Permission To Release Health Information

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and/or health practitioners.

Person completing the form: Signature _____

Witness_____ Print Name _____

If other than patient, indicate relationship _____ Date _____/_____/_____