Patient History & Information

Patient Social Security No:_____ Today's Date: _____
Email Address: _____ Birth Date: _____

PATIENT INFORMATION

Name: _____Age:_____ Sex: _____ Marital Status: _____
Last First Middle
Preferred Name: _____
Address (Home):_____
Street City State/Zip
Home Phone: _____Cell:_____
Employer: _____Phone:_____
Employer Address:_____
Street City State/Zip

Name of Spouse: _____Cell Phone: _____
Spouse Employer: _____Work Phone: _____
Spouse Employer Address: _____
Street City State/Zip

Contact Person in Case of Emergency (Other than Spouse): _____
Phone No: _____

- Who may we thank for referring you to us:_____
- Name of Previous Dentist_____

DENTAL/MEDICAL HISTORY

1. Check any of the following which you have had or have at the present time.

☐ ADD
☐ ADHD
☐ AIDS/HIV Virus
☐ Allergies or Hives
☐ Anemia
☐ Angina Pectoris
☐ Arthritis
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Blood Transfusion
☐ Bruise Easily
☐ Chemotherapy (Cancer, Leukemia)
☐ Cold Sores
☐ Congenital Heart Lesions
☐ Cortisone Medicine
☐ Cough
☐ Diabetes
☐ Drug Addiction
☐ Emphysema
☐ Epilepsy or Seizures
☐ Fainting or Dizzy Spells
☐ Fever Blisters
☐ Gags Easily
☐ Genital Herpes
☐ Glaucoma
☐ Gonorrhea
☐ Hay Fever
☐ Heart Disease or Attack
☐ Heart Failure
☐ Heart Murmur
☐ Heart Pacemaker
☐ Heart Surgery
☐ Hemophilia
☐ Hepatitis A (infections)
☐ Hepatitis B (serum)
☐ High Blood Pressure
☐ Kidney Trouble
☐ Liver Disease
☐ Lupus
☐ Migraines
☐ Multiple Sclerosis
☐ Nervousness/Anxiety
☐ Pain in Jaw or Face
☐ Psychiatric Treatment
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Sickle Cell Disease
☐ Sinus Troubles
☐ Stroke
☐ Syphilis
☐ Thyroid Disease
☐ Tuberculosis (TB)
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Xray/RadiationTherapy
☐ Yellow Jaundice

CIRCLE

2. Are you having dental pain or discomfort at this time? ..... Yes No
   If yes, please describe_____
3. Do you feel nervous about have dental treatment? ..... Yes No
4. Have you ever had a bad experience in the dental office? ……..…….Yes No
   If yes, please describe_____
5. Name of Medical Physician_____ Phone:_____
6. Have you been a patient in the hospital in the past two years? ……..… Yes No
7. Have you been under the care of a medical doctor during the past two years? ……..… Yes No
8. Have you taken any medicine of drugs during the past two years? ……..…. Yes No
   If yes, please describe_____
   _____
   _____

9. Have you ever had excessive bleeding requiring special treatment? …….……..… Yes No
10. Are you allergic to (i.e. itching, rash, swelling of hands, feet, or eyes) or made sick by penicillin, aspirin, codeine, or any other medicines and/or latex? …… Yes No
    If yes, please list_____
11. When you walk up the stairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath, or because you are very tired? ..... Yes No
12. Do your ankles swell during the day? …… …… Yes No
13. Do you use more than 2 pillows to sleep? …….. Yes No
14. Have you lost or gained more than 10 pounds in the past year? …… Yes No
15. Do you ever wake up from sleep short of breath? …….. Yes No
16. Are you on a special diet? ……... Yes No
17. Are you pregnant? …….……..…..Yes No
18. Do you ☐ smoke ☐ dip or ☐ chew? ……Yes No
    If yes, how often or how much? _____
19. Do you have hearing loss? ……Yes No
20. Any other medical conditions, diseases, or concerns that are not listed above? …… Yes No
    If yes, please list:

    _____
    _____

AGREEMENT OF TREATMENT AND PAYMENT:

I consent to treatment as determined by the attending dentist, including, whatever drugs, medicine, x-rays or other studies necessary to confirm the diagnosis and treatment of my symptoms by the attending dentist, dental assistant, hygienist, and qualified designate.
I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify all the preceding information is true and correct to the best of my knowledge. If I have any changes in my status, health or if my medicine(s) change, I will inform the dentist at the next appointment without fail.

Signature of Patient, Parent or Guardian **Date**