PATIENT INFORMATION AND HEALTH HISTORY

We are complimented that you have selected us to provide for your dental care. Please complete this new patient information and medical and dental health history form. (This information is necessary for our files and will be considered confidential.)

Personal Information

Purpose of Visit _____ Date _____

Patient's Name _____ Age _____ Birthday _____
LAST *FIRST* *INITIAL*

Residence Address _____
STREET *CITY* *ZIP*

Marital Status is ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor ☐ Clergy

Best contact: ☐ Email _____ ☐ Cell Phone _____ ☐ Other _____

If student, name of school _____

Driver's License No. _____ Social Security No. _____ Home Phone ( ) _____

Employed by _____ How Long? _____ Occupation _____

Business Address _____ Work Phone ( ) _____
STREET *CITY* *ZIP*

Spouse's Name _____ Soc. Sec. No. _____

Employed by _____ How Long? _____ Occupation _____

Business Address _____ Day.Phone ( ) _____
STREET *CITY* *ZIP*

Name of nearest relative not living with you _____ Relationship _____

Complete Address _____ Eve.Phone ( ) _____
STREET *CITY* *ZIP*

Name of Physician _____
ADDRESS *CITY* *TELEPHONE*

Name of Dentist _____
ADDRESS *CITY* *TELEPHONE*

Is this office visit for Emergency Dental Care? ☐ Yes ☐ No If yes, explain: _____

Who may we thank for referring you? _____

Financial Information

Person responsible for this account _____ Relationship _____

Address _____
STREET CITY ZIP TELEPHONE

PAYMENT PREFERENCE ☐ Cash day of treatment ☐ Visa ☐ MC ☐ Discover CC # _____ Exp _____

☐ Care Credit Payment Plan _____ ☐ Debit Checking Acct. # _____

If you have insurance that may cover any part of our professional services please list your Insurance carriers.

DENTAL INSURANCE Name of insurance company _____

INSURED PERSONS NAME | BIRTHDATE | RELATIONSHIP | SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN | GROUP NO. | PLAN NO. | NAME OF UNION | LOCAL

Secondary Dental Insurance Company _____

INSURED PERSON'S NAME | BIRTHDATE | RELATIONSHIP | SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN | GROUP NO.. | PLAN NO. | NAME OF UNION | LOCAL

MEDICAL INSURANCE (primary insurance) _____

INSURED PERSON'S NAME | BIRTHDATE | RELATIONSHIP | SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN | GROUP NO. | PLAN NO. | NAME OF UNION | LOCAL

Secondary Medical Insurance Company _____

INSURED PERSONS NAME | BIRTHDATE | RELATIONSHIP | SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN | GROUP NO. | PLAN NO. | NAME OF UNION | LOCAL

Medical History

Please answer each question. Check Yes or No where applicable.

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Y N

☐☐ Are you in good health?
Date of last physical examination _____

☐☐ Are you now under the care of a physician?
It so, what is the condition being treated? _____

☐☐ Have you ever had any serious illness or operation?
If so, what illness or operation? _____

☐☐ Have you ever been hospitalized?
If so, what was the problem? _____

☐☐ Are you taking any medications?
If so, what? _____ What dosage? _____

☐☐ Have you ever been pre-medicated with antibiotics for your dental treatment?

☐☐ Are you sensitive or allergic to any drugs? ☐ Penicillin ☐ Tetracycline ☐ Sulfa drugs ☐ Aspirin ☐ Codeine
☐ Other If Other, what drugs? _____

Do you now have or have you had any of the following: (Please check Yes or No for known conditions)

Y N		Y N		Y N		Y N		Y N	
☐☐	Anemia	☐☐	Hemophilia	☐☐	Drug Addiction	☐☐	Nervous Disorders	☐☐	Sickle Cell Disease
☐☐	Herpes	☐☐	Rheumatism	☐☐	Kidney Disease	☐☐	Tumors of Growths	☐☐	Tuberculosis (T.B.)
☐☐	Stroke	☐☐	Heart Murmur	☐☐	Stomach Ulcers	☐☐	Allergies or Hives	☐☐	Epilepsy or Seizures
☐☐	Diabetes	☐☐	Bruise easily	☐☐	Angina Pectoris	☐☐	Cortisone Medicine	☐☐	Artificial Prosthesis
☐☐	Glaucoma	☐☐	Head Injuries	☐☐	Mental Disorder	☐☐	Excessive Bleeding	☐☐	Psychiatric Treatment
☐☐	Arthritis	☐☐	Heart Failure	☐☐	Rheumatic Fever	☐☐	Asthma	☐☐	Congenital Heart Lesions
☐☐	Emphysema	☐☐	Liver Disease	☐☐	Thyroid Disease	☐☐	High Blood Pressure	☐☐	Heart Ailments or Attack
☐☐	Hay Fever	☐☐	Sinus Trouble	☐☐	Cerebral Palsy	☐☐	AIDS Related Complex	☐☐	Hepatitis or Jaundice
☐☐	Cold Sores	☐☐	Blood Disease	☐☐	Joint Replacement	☐☐	Respiratory Disease	☐☐	Fainting Spells or Seizures
☐☐	Chemotherapy (Cancer, Leukemia)			☐☐	Radiation Treatment	☐☐	Taken Phen Phen	☐☐	X-Ray or Cobalt Treatment
☐☐	Venereal Disease (Syphilis, Gonorrhea)			☐☐	AIDS			☐☐	Other _____
☐☐	Skin Disorders _____					☐☐	Bisphosphonates _____		

Y N

☐☐ **Do you wear a cardiac pacemaker, or have you had heart surgery?**

☐☐ **Do you have any disease, condition or problem not listed that you think I should know about?**
If so, what? _____

☐☐ **(Women) Are you pregnant? If so, how many months?** _____

☐☐ **(Women) Do you take birth control pills?**

☐☐ **Have you ever had any unfavorable reaction from a local anesthetic?**

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Date_____ Signature _____

Year 2
Changes in Health _____
Date_____ Signature _____

Year 3
Changes in Health _____
Date _____ Signature _____

Health Questionnaire MUST be updated every year!

REVIEWED BY

YEAR 1

YEAR 2

YEAR 3

DO NOT WRITE IN THIS SPACE

	Year I	Year 2	Year 3
Date			
BP	___/___	___/___	___/___
Pulse			
Ternp			
By			

Consent for Treatment

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form to administer such anesthetics, analgesics, sedatives and nitrous oxide sedation; to obtain the necessary records and photographs and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

The patient (parent or guardian) is fully responsible for total payment of all services performed in this office including any amounts not covered by any health insurance program the responsible party may have. Should collection procedures be required to collect a past due account, I will pay all fees associated with said collection procedures as allowed by law.

Signed: _____ Date: _____ Relationship to the patient: _____
Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Received &
Witnessed by _____ Date _____ Reviewed by Dr. _____ Date _____

Name _____ Date _____

Dental History

How long has it been since your last dental examination? _____

Y N

Complete mouth x-ray examination? _____ Dental Prophylaxis? _____

☐☐ Have you had orthodontic treatment?
If YES. when? _____

☐☐ Do you have unreplaced missing teeth?
If YES, why haven't you had them replaced? _____ Was it ever suggested? _____

☐☐ Do your gums bleed when brushing your teeth?

☐☐ Have you ever been told that you have periodontal disease (pyorrhea, gum disease)?

☐☐ Have you ever had professional instructions on dental home care?

☐☐ Is any part of your mouth sensitive to temperature or pressure_?
If YES where? _____

☐☐ Does food catch between your teeth?
If YES, where? _____

☐☐ Do you have any unpleasant odor or taste in your mouth?

☐☐ Are you dissatisfied with your teeth or their appearance?

☐☐ Do you always have something to be treated or required when you visit a dentist?

☐☐ Do you feel that in the past you have required a lot of dental work?
If YES, has it been to replace previous dentistry or to repair a new decay? ☐ Replace ☐ New Decay

☐☐ Are you aware that dental decay is essentially a childhood disease, and that most tooth filling procedures are to replace broken fillings or temporary dentistry?

Dentures

Y N

☐☐ Do any members of your family, including your parents, wear dentures?

How long have you worn dentures? _____

How many dentures do you wear? _____

How many dentures have your worn? Upper _____ Lower _____

Why were your teeth extracted? _____

If you are currently having a denture problem, is it related to:

Pain ☐ Discomfort ☐ Appearance ☐ Function ☐

if you are a candidate for new or replacement dentures, how do you feel about getting dentures?

_____

Other Doctors

Your prior medical and dental experiences are of great value to us in assessing your present problem and determining to whom you would like to be referred should specialized care be required. Please list names of the following health care professionals who have or are now caring for you.

_____ GENERAL DENTIST	_____ PROSTHODONTIST	_____ PERSONAL PHYSICIAN
_____ ENDODONTIST	_____ ORAL SURGEON	_____ ORTHODONTIST
_____ PERIODONTIST	_____ OTHER	_____ OTHER

Occlusal Screening

Y	N	
☐	☐	Do you clench or grind your teeth during the day?
☐	☐	Have you been made aware of clenching or grinding your teeth during the night?
☐	☐	Do you have chronic headaches or neck and shoulder pains?
☐	☐	Do you ever awaken with an awareness about your teeth or jaw like you have had them clenched in your sleep?
☐	☐	Do you have any awareness (tightness, stiffness. pain) of the muscles in your neck or shoulders?
☐	☐	Do you now have. or have you ever had, pain in your jaw joint or the sides of your face?
☐	☐	Do you have any pain or soreness about your eye? ☐ Right ☐ Left (Check which)
☐	☐	Do you have a clicking jaw joint or have you ever experienced an inability to move your jaw or open your mouth widely?
		Which side do you chew on? (Check one): ☐ Right ☐ Left ☐ Both
☐	☐	Do you have difficulty swallowing?
☐	☐	Do you habitually bite your cheek, tongue or lip?
☐	☐	Do you play the violin, a wind instrument or do you snorkel or scuba dive?
☐	☐	Do you have recurring episodes of any of the following: (Please check those that apply.)

☐ Earache ☐ Ear congestion ☐ Loss of hearing acuity ☐ Tinnitus (ringing in the ears) ☐ Dizziness

I have completed this preclinical examination questionnaire to the best of my knowledge.

Signature _____ Date _____

Received & Witnessed by _____ Reviewed by Dr. _____

Dental Records Policy

The dental records policy of this office reflects the patient's right to expect that his/her dental records be treated in confidence. Dental records are the property of the office and are maintained for the benefit of the patient and doctor(s).

☐ **Dental Records Release:** I hereby consent to the release of dental records, x-rays and photographs obtained in the diagnosis and treatment of my dental needs to be used for documentation, education, research and advancement in the field of medicine / dentistry and to be used by other therapists involved in my care.

Signature _____ Date _____

Correction: Please re-sign and date _____

Additional Comments