

PATIENT INFORMATION AND HEALTH HISTORY

INITIAL EXAM

DATE _____

PATIENT'S NAME _____

SINGLE MARRIED LONG TERM PARTNER DIVORCED SEPARATED WIDOWED

DATE OF BIRTH _____

PATIENT'S ADDRESS _____ PHONE _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ PHONE _____

ADDRESS _____

EMPLOYED BY _____ BUSINESS PHONE _____

BUSINESS ADDRESS _____ PATIENT'S SS # _____

DENTAL INSURANCE PLAN (IF ANY) _____ REFERRED BY _____

PATIENT'S NAME

DENTAL HISTORY

CHIEF ORAL COMPLAINT _____

DATE OF LAST DENTAL EXAM. _____ ANY PREVIOUS MAJOR DENTAL TREATMENT, ☐ YES ☐ NO WHEN _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- | | | |
|--|---|--|
| ☐ Teeth sensitive to cold, heat, sweets or pressure | ☐ Bad breath | ☐ Cigarettes, pipe or cigar smoking |
| ☐ Bleeding gums. How long _____ | ☐ Unpleasant taste | ☐ Texture of toothbrush _____ |
| ☐ Food impaction | ☐ Unfavorable dental experience | ☐ Frequency of brushing _____ |
| ☐ Clenching or grinding of teeth | ☐ Complications from extractions | ☐ Dental Floss |
| ☐ Burning of tongue | ☐ Periodontal treatment | ☐ Inter dental stimulators |
| ☐ Swelling or lumps in mouth | ☐ Orthodontic treatment | ☐ Water jet device |
| ☐ Frequent blisters on lips or mouth | ☐ Mouth breathing | ☐ Disclosing tablets or solution |
| ☐ Pain around ear | ☐ Oral habits; thumbsucking, fingernail biting, cheek biting, etc. | ☐ Fluoride supplements |
| ☐ Unusual sounds in ear while eating | | ☐ Alcohol |

MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM _____ AGE _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- | | | |
|--|--|---|
| ☐ Allergies to drugs | ☐ Asthma | ☐ Immune System Disorders (AIDS, HIV, ARC) |
| ☐ Allergies to anesthetics | ☐ Hay fever or allergies in general | ☐ Stroke |
| ☐ Any heart ailments | ☐ Diabetes | ☐ Thyroid |
| ☐ High blood pressure | ☐ Kidney problems | ☐ Eye disorders |
| ☐ Neurological problems | ☐ Latex sensitivity | ☐ Tonsillitis |
| ☐ Radiation treatments | ☐ Liver problems or hepatitis | ☐ Tuberculosis |
| ☐ Excessive bleeding from cut or extraction | ☐ Malignancies | ☐ Ulcer or colitis |
| ☐ Anemia or blood problems | ☐ Psychiatric care/emotional problems | ☐ Pregnancy If so, what month _____ |
| ☐ Arthritis | ☐ Rheumatic fever | ☐ Venereal disease |
| ☐ Chronic Fatigue Syndrome | ☐ Sinus problems | ☐ Other _____ |

Describe any current medical treatment including drugs taken, even though not listed above _____

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the 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 misunderstandings 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.

Signature _____ Date _____
(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)