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## Patient History and Information

Date: \_\_\_\_\_

Dr Mr  
 Name: Miss Ms \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Spouse/Guardian Name: \_\_\_\_\_ Marital Status: S M D W Gender: M F  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Best way to reach you During the Day: \_\_\_\_\_ Email: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Emergency Contact Name: \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_  
 Social Security No.: \_\_\_\_\_ Driver's License No.: \_\_\_\_\_  
 Dental Insurance?  Yes  No Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Who Referred You to Us? \_\_\_\_\_  
 What are your Hobbies/Special Interests? \_\_\_\_\_

### Dental History

Date of Last Dental Exam: \_\_\_\_\_ Name/Location of Former Dentist: \_\_\_\_\_  
 What brings you to our Office? \_\_\_\_\_

Please Answer the Following Questions (Descriptions can be placed under Remarks):

|                                      | Yes                      | No                       |  | Yes                      | No                       |
|--------------------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Discomfort with Hot liquids/foods    | <input type="checkbox"/> | <input type="checkbox"/> | Do you Brush (Frequency _____)           | <input type="checkbox"/> | <input type="checkbox"/> |
| Discomfort with Cold liquids/foods   | <input type="checkbox"/> | <input type="checkbox"/> | Do you Floss (Frequency _____)           | <input type="checkbox"/> | <input type="checkbox"/> |
| Discomfort with Sweets/Sours         | <input type="checkbox"/> | <input type="checkbox"/> | Do your Gums Bleed                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Sensitivity in one area of the mouth | <input type="checkbox"/> | <input type="checkbox"/> | Gums feel Tender/ Swollen                | <input type="checkbox"/> | <input type="checkbox"/> |
| Jaw Joint Sounds                     | <input type="checkbox"/> | <input type="checkbox"/> | Past Diagnosis/Treatment for Gum Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Chewing on One Side of the Mouth     | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any "Loose" Teeth            | <input type="checkbox"/> | <input type="checkbox"/> |
| Jaw Locking or Catching              | <input type="checkbox"/> | <input type="checkbox"/> | Pain in Face or Inside the Mouth         | <input type="checkbox"/> | <input type="checkbox"/> |
| Jaw Pain or Aches                    | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty Opening/Closing/Chewing   | <input type="checkbox"/> | <input type="checkbox"/> | Injury to the Face/Head/Neck             | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have Missing Teeth            | <input type="checkbox"/> | <input type="checkbox"/> | Clenching or Grinding Teeth              | <input type="checkbox"/> | <input type="checkbox"/> |
| Prolonged Bleeding after Extractions | <input type="checkbox"/> | <input type="checkbox"/> | Worn Braces or had Orthodontics          | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear a Partial Denture        | <input type="checkbox"/> | <input type="checkbox"/> | → If so, how long? _____ Fits good?      | <input type="checkbox"/> | <input type="checkbox"/> |
| Upper and/or Lower Dentures          | <input type="checkbox"/> | <input type="checkbox"/> | → If so, how long? _____ Fits good?      | <input type="checkbox"/> | <input type="checkbox"/> |

Remarks: \_\_\_\_\_

|   | Yes                      | No                       |                                      | Yes                      | No                       |
|---|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|
| Do you like the way your teeth look?                                    | <input type="checkbox"/> | <input type="checkbox"/> | Any interest in Whitening/Bleaching? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is there any Previous or Older Dental Treatment you are not happy with? |                          |                          |                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| What would you like to Change about your Smile?                         |                          |                          | _____                                |                          |                          |

|  |                          |                          |
|--|--------------------------|--------------------------|
| I desire to keep my own teeth for life. I want my teeth to feel good, look good, and last.   | <input type="checkbox"/> | <input type="checkbox"/> |
| I am interested in a plan for long-term dental health.                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Phasing Treatment, by Priority, may make it feasible for me to achieve the results I desire. | <input type="checkbox"/> | <input type="checkbox"/> |
| A Payment Plan through a Secondary Company may help me achieve the results I desire.         | <input type="checkbox"/> | <input type="checkbox"/> |

|  |                          |                          |
|--|--------------------------|--------------------------|
| Are you Anxious about Dental Treatment?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever required "Pre-Medication" Antibiotics before your dental work? | <input type="checkbox"/> | <input type="checkbox"/> |
| Please List any Additional Concerns about your mouth _____                   |                          |                          |

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## Medical History

Physician's Name \_\_\_\_\_ Phone: \_\_\_\_\_

When did you last Consult a Physician? \_\_\_\_\_ Reason: \_\_\_\_\_

General Health (please check): Excellent  Good  Fair  Poor

Please List any Hospitalizations, Surgeries, or Injuries in the Past 5 Years (include Complications) \_\_\_\_\_

Do You Smoke or Use Tobacco: Yes  No  If Yes, how much? \_\_\_\_\_

Do You Drink Alcohol: Yes  No  If Yes, how much? \_\_\_\_\_

Are you Taking Any or Supposed to be taking Any Medications? Yes  No  (Please List Name, Dosage, and Frequency) – Include Over the Counter Medications, Vitamins, Pain Relievers, and Birth Control

Are you Aware of any **Drug Allergies** including Antibiotics or Anesthetics? Yes  No  (Please List):

Are You **Allergic to Latex**? Yes  No  Metals? Yes  No  Acrylics? Yes  No

To the best of your Knowledge, have you ever had or Suspected any of the Following:

|                           | Yes                      | No                       |   | Yes                      | No                       |                           | Yes                      | No                       |
|---------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|
| High Blood Pressure       | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes Type _____                                 | <input type="checkbox"/> | <input type="checkbox"/> | Artificial Hip, Knee, etc | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure        | <input type="checkbox"/> | <input type="checkbox"/> | Fatigue/Weakness                                    | <input type="checkbox"/> | <input type="checkbox"/> | Osteoarthritis            | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest Pain                | <input type="checkbox"/> | <input type="checkbox"/> | Fainting/Dizzy Spells                               | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis      | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack              | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures                                   | <input type="checkbox"/> | <input type="checkbox"/> | Neck/Back Problems        | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke                    | <input type="checkbox"/> | <input type="checkbox"/> | Panic Attacks                                       | <input type="checkbox"/> | <input type="checkbox"/> | Migraines/Headaches       | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Pace Maker          | <input type="checkbox"/> | <input type="checkbox"/> | Depression  | <input type="checkbox"/> | <input type="checkbox"/> | Taking Steroids           | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever           | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Treatment                               | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease           | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur              | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety Disorder                                    | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease            | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral Valve Prolapse     | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis Type _____                                | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease             | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Heart Valve    | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss                                  | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease          | <input type="checkbox"/> | <input type="checkbox"/> |
| Use <b>Pre-Medication</b> | <input type="checkbox"/> | <input type="checkbox"/> | Gastric Reflux                                      | <input type="checkbox"/> | <input type="checkbox"/> | AIDS/ HIV Infection       | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia                    | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis  | <input type="checkbox"/> | <input type="checkbox"/> | Tumor/Cancer History      | <input type="checkbox"/> | <input type="checkbox"/> |
| Hemophilia                | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Disease                                 | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Treatment       | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking Blood Thinner      | <input type="checkbox"/> | <input type="checkbox"/> | Asthma  | <input type="checkbox"/> | <input type="checkbox"/> | Recreational Drug Use     | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding Disorder         | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems                                      | <input type="checkbox"/> | <input type="checkbox"/> | Are You Pregnant?         | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoporosis              | <input type="checkbox"/> | <input type="checkbox"/> | → Are you taking Fosamax® or any Bone Density Drug? | <input type="checkbox"/> | <input type="checkbox"/> |                           |                          |                          |
| Osteopenia                | <input type="checkbox"/> | <input type="checkbox"/> | → Please list Any Bone Density Meds:                | _____                    |                          |                           |                          |                          |

Please List Any other Medical Conditions not mentioned above: \_\_\_\_\_

## Acknowledgement and Authority

I consent to treatment as necessary or desirable to the care of the patient first named above. Including, but not limited to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor, or his nurse of qualified designate.

I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, AT THE TIME OF SERVICE, unless other arrangements are made with the Financial Department. In the event of Default, the undersigned applicant agrees to pay interest at the rate of 1 ½ % per month on any outstanding balance (18% Annual Interest). In addition, the undersigned applicant agrees to pay all court costs and attorney's fees reasonably necessary for collections, including attorney fees on appeal.

Signed: (Patient, Parent or Agent, must be 18) \_\_\_\_\_ Date: \_\_\_\_\_