PATIENT INFORMATION

HOW DID YOU FIND OUT ABOUT OUR OFFICE? PLEASE CHECK ONE:

- FRIEND OR FAMILY – THEIR NAME: ____________________
- YELLOW PAGES
- RECEIVED AN ADVERTISING POST CARD / FLYER
- BUILDING SIGN
- TV COMMERCIALS
- OTHER ____
- INSURANCE BOOK

PATIENT'S NAME: ____
FIRST INITIAL LAST

PATIENT ADDRESS: ____
STREET CITY STATE ZIP

SOC. SEC. NO.: ____________________ HOME PHONE NO. (_______)_________-_____________BUSINESS PHONE NO. (_______)_________-___________

CELL NUMBER NO. (_______)_________-_________________EMAIL ____

[] MALE [] FEMALE [] MARRIED [] YES [] NO BIRTHDATE: __________________ AGE: ________ [] MINOR

IF PATIENT IS MINOR, GIVE PARENT'S OR GUARDIAN'S NAME: ________________________________ RELATIONSHIP________________________

DOB ____________________DRIVER'S LICENSE NO. __________________________ EMPLOYED BY ____

EMPLOYER'S ADDRESS ____
STREET CITY STATE ZIP

INSURED NAME ____ DOB _________________ EMPLOYED BY _______________________________________

SPOUSE'S NAME _______________________________ DRIVER LIC. NO ___________________________ SOC. SEC. NO.__________-________-__________

SPOUSE EMPLOYER ___________________________ OCCUPATION ________________________ BUSINESS PHONE NO. (_______)_________-__________

SPOUSE'S EMPLOYER'S ADDRESS ____
STREET CITY STATE ZIP

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU ____RELATIONSHIP: ______________________

RELATIVE'S ADDRESS:____ HOME PHONE NO. (_______)_________-_________________
STREET CITY STATE ZIP

PATIENT'S PHYSICIAN ____BUSINESS PHONE NO. (_______)_________-_________________

PHYSICIAN'S ADDRESS ____
STREET CITY STAE ZIP

PATIENT'S FORMER DENTIST ____ BUSINESS PHONE NO. (_______)_________-_________________

FORMER DENTIST'S ADDRESS____
STREET CITY STAE ZIP

DENTAL HISTORY

1. HAVE YOU EVERHAD A LOCAL ANESTHETIC (NOOVAI, ETC.)?..[] YES [] NO
2. HAVE YOU EVER HAD ANY UNFAVORABLE REACTION FROM A LOCAL ANESTHETIC?..[] YES [] NO
3. HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WIH PREVIOUS DENTAL TREATMENT?......... …………[] YES [] NO

   IF SO, PLEASE EXPLAIN ____
4. HOW LONG SINCE YOUR LAST FULL MOUTH OF X-RAYS? ____________/________________/_________________
5. HOW LONG SINCE YOUR LAST DENTAL TREATMENT? ____________/________________/_________________
6. DOES DENTAL TREATMENT MAKE YOU NERVOUS?……[] SLIGHTLY [] MODERATELY [] EXTREMELY [] NO
7. ARE YOU IN PAIN? ………………………………………………………………………..…………………........................[] YES [] NO
8. WHAT IS YOUR MAIN COMPLAINT? ____
9. ARE YOU INTERESTED IN TEETH WHITENING? ____

CONSENT FOR TREATMENT

THE HEALTH HISTORY I HAVE WRITTEN ON THE FRONT & BACK OF THIS FORM IS COMPLETE & CORRECT TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE & GIVE CONSENT TO PERFORM DENTAL SERVICES AGREED BETWEEN DOCTOR & PATIENT AND/OR GUARDIAN TO BE NECESSAR OR ADVISABLE, INCLUDING THE USE OF LOCAL ANESTHETIA & OTHER MEDICATION AS INDICATED. I AGREE THAT, REGARDLESS OF INSURANCE COVERAGE I AM RESPONSIBLE FOR PAYMENT FOR SERVICES RENDERED & THAT A FINANCE CHARGE OF 1 ½ % (ONE & ONE HALF PECENT) WILL BE APPLIED TO ACCOUNTS OVER SIXTY DAYS PAST DUE.

X____ **DATE:** ______________________________

SIGNITURE OF PATIENT, PARENT OR GUARDIAN

Patient Name: ______________________________ **Date:** ________________

MEDICAL HISTORY

THESE QUESTIONS ARE FOR YOUR BENEFIT & ASSURE THAT TREATMENT WILL TAKE INTO CONSIDERATION YOUR PAST & PRESENT HEALTH STATUS. SOME QUESTIONS MAY SEEM UNRELATED TO YOUR DENTAL CONDITION, BUT THEY ARE ALL ASSOCIATED WITH PROPER ORAL HEALH CAE. PLEASE ANSWER EACH QUESTION.

1. ARE YOU IN GOOD HEALTH? [] YES [] NO
2. DATE OF LAST PHYSICAL EXAMINATION _____________/_______________/_____________
3. ARE YOU UNDER THE CARE OF A PHYSICIAN? [] YES [] NO
   IF SO, WHAT IS THE CONDITION BEING TREATED? ______________________________
4. HAVE YOU EVER HAD ANY SERIOUS ILLNESS OR OPERATION? [] YES [] NO
   IF SO, WHAT ILLNESS OR OPERAION? ______________________________
5. HAVE YOU EVER BEEN HOSPITALIZED? [] YES [] NO
   IF SO, WHAT WAS THE PROBLEM? ______________________________
6. ARE YOU TAKING ANY DRUGS OR MEDICINE? [] YES [] NO
   IF SO, WHAT?____________________________ WHAT DOSAGE? ------------------------------
7. ARE YOU SENSITIVE OR ALLERGIC TO ANY DRUGS? [] YES [] NO IF YES, WHICH DRUGS? [] PENICILLIN [] TETRACYCLINE
   [] SULFA DRUGS [] ASPIRIN [] CODEINE [] OTHER IF OTHER, WHAT DEUGS? ______________________________
8. ARE YOU SENSITIVE TO LATEX? [] YES [] NO
9. HAVE YOU EVER TAKEN PRESCRIPTION MEDICATION FOR WEIGHT LOSS (DIET PILLS)? [] YES [] NO
   IF YES, DID YOU TAKE ANY OF THE FOLLOWING?
   - FEN-PHEN (FENFLURAMINE-PHENPERMINE) [] YES [] NO
   - PONDIMINE (FENFLURAMINE) [] YES [] NO
   - RENDUX (DEXFENFLURAMINE) [] YES [] NO
10. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (PLEASE CHECK "YES OR NO"):

YES	NO	YES	NO	YES	NO	YES	NO
[ ]	[ ] ANEMIA	[ ]	[ ] BRUISE EASILY	[ ]	[ ] CEREBRAL PALSY	[ ]	[ ] EPILEPSY OR SEIZURES
[ ]	[ ] HERPES	[ ]	[ ] HEAD INJURIES	[ ]	[ ] BLOOD TRANSFUSION	[ ]	[ ] ARTIFICIAL PROSTHESIS
[ ]	[ ] STROKE	[ ]	[ ] HEART FAILURE	[ ]	[ ] JOINT REPLACEMENT	[ ]	[ ] PSYCHIATRIC TREATMENT
[ ]	[ ] ULCERS	[ ]	[ ] LIVER DISEASE	[ ]	[ ] NERVOUS DISORDER	[ ]	[ ] CONGENITAL HEART LESIONS
[ ]	[ ] DIABETES	[ ]	[ ] SCARLET FEVER	[ ]	[ ] TUMORS OR GROWTHS	[ ]	[ ] DIFFICULTY SWALLOWING
[ ]	[ ] GLAUCOMA	[ ]	[ ] CHICKEN POX	[ ]	[ ] ALLERGIES OR HIVES	[ ]	[ ] HEART AIMENTS OR ATTACK
[ ]	[ ] ARTHRITIS	[ ]	[ ] SINUS TROUBLE	[ ]	[ ] EXCESSIVE BLEEDING	[ ]	[ ] X-RAY OR COBALT TREATMENT
[ ]	[ ] EMPHYSEMA	[ ]	[ ] BLOOD DISEASE	[ ]	[ ] ASTHMA	[ ]	[ ] FAINTING SPELLS OR SEIZURES
[ ]	[ ] HAY FEVER	[ ]	[ ] DRUG ADDICTION	[ ]	[ ] HIGH BLOOD PRESSURE	[ ]	[ ] CHEMOTHERAPY(CANCER, LEUKEMIA)
[ ]	[ ] TONSILLITIS	[ ]	[ ] KIDNEY DISEASE	[ ]	[ ] AIDS RELATED COMPLEX	[ ]	[ ] RADIATION TREATMENT OF ANY KIND
[ ]	[ ] COLD SORES	[ ]	[ ] ANGINA PECTORIS	[ ]	[ ] PAIN IN JAW JOINTS	[ ]	[ ] HEPATITIS OR JAUNDICE
[ ]	[ ] HEMOPHILLIA	[ ]	[ ] MENTAL DISORDER	[ ]	[ ] RESPIRATORY DISEASE	[ ]	[ ] VENEREAL DISEASE (SYPHILIS, GONORHEA)
[ ]	[ ] RHEUMATISM	[ ]	[ ] RHEUMAIC FEVER	[ ]	[ ] SICKLE CELL DISEASE	[ ]	[ ]ACQUIRED IMMUNE DEFICIENY SYNDROME
[ ]	[ ] HEART MURMUR	[ ]	[ ] THYROID DISEASE	[ ]	[ ] TUBERCULOSIS (TB)	[ ]	[ ] OTHER ____________________

11. DO YOU WEAR A CARDIAC PACEMAKER OR HAVE YOU HAD HEART SURGERY?.. [] YES [] NO
12. DO YOU TAKE OR HAVE YOU EVER TAKEN BISPHOSPHONATES (FOSAMAX, BONIVA, ACTENOL, AREDIAZOMETA, ETC.) FOR OSTEOPOPOSISORANY OTHER CONDITION ……………………………………………………………………………………[] YES [] NO
13. DO YOU HAVE ANY DISEASESM, CONDITION OR PROBLEMS NOT LISTED THAT YOU THINK I SHOULD KNOW ABOUT [] YES [] NO
    IF SO, WHAT? ______________________________
14. (WOMEN) ARE PREGNANT? ……..[] YES [] NO IF SO, HOW MANY MONTHS?______________________________
15. (WOMEN) DO YOU HAVE ANY PROBLEMS ASSOCIATED WITH YOUR MENSTRUL PERIOD? ……………………….[] YES [] NO
16. (WOMEN) DO YOU TAKE BIRTH CONTIROL PILLS?.. [] YES [] NO

TO THE BEST OF MY ACKNOWLEDGE, 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 FALL, INFORM THE DOCTOR AT MY NEXT APPOINTMENT.

Date:____________________________ **SIGNATURE:**____________________________________

YEAR 2:
CHANGES IN HEALTH: ____
DATE:________________ SIGNATURE:______________________________________
YEAR 3:
CHANGES IN HEALTH:____
DATE:________________ SIGNATURE:______________________________________
HEALTH QUESTIONS SHOULD BE UPDATED EACH YEAR

DO NOT WRITE IN THIS SPACE – OFFICE USE ONLY				
REVIEWED BY		YEAR 1	YEAR 2	YEAR 3
INITIALS YEAR 1:	DATE			
INITIALS YEAR 2:	BP: PULSE:			
INITIALS YEAR 3:	PULSE:			

COMMENTS ON DENTAL AND MEDICAL HISTORY

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