PATIENT HISTORY AND INFORMATION

(Confidential information for our files)

(Please Print Clearly) Date _____

Name Mr / Mrs / Miss / Ms _____ Birth Date _____

Social Security Number _____ Driver License Number _____

Residence Address _____ Phone ( ) _____
Street City State Zip

Employed By _____ Occupation _____ Phone ( ) _____

Business Address _____
Street City State Zip

Marital Status _____ Spouse's Name _____ Birth Date _____

Employed By _____ Bus. Phone ( ) _____ Soc Sec No _____

Spouse's Business Address _____
Street City State Zip

Whom May We Thank For Referring You To Our Office? _____

Person Financially Responsible? _____ Phone ( ) _____ Relationship _____

Res. Address (If Different From Above) _____
Street City State Zip

Do You Have Dental Insurance Through Your Employer? _____ Name Of Carrier _____

Does Your Spouse Have Dental Insurance Through Their Employer? _____ Carrier _____

Patient Dental History

Yes No Are you experiencing pain or discomfort from your mouth at this time? Describe _____
Yes No Are your teeth sensitive to cold, hot or sweets? Describe _____
Yes No Do your gums ever bleed? When? _____
Yes No Have you ever noticed loose teeth? Where? _____
Yes No Have you noticed any bad odors or tastes from your mouth?
Yes No Does food wedge between any of your teeth? Where? _____
Yes No Have you had your teeth cleaned? When? _____
Yes No Have you ever had periodontal (gum) treatment? When? _____
Yes No Would you like to improve the appearance of your teeth?
Yes No Have you ever worn braces to straighten your teeth? When? _____
Yes No Do you wear partial dentures or dentures? When were they made? _____
Yes No Would you be disturbed if you had to lose your teeth and wear dentures?
Yes No Have you been under more nervous tension than usual?
Yes No Do you clench, or grind your teeth in the daytime or at night?
Yes No Does your jaw pop or click when you open or chew?
Yes No Do you ever have pain in the region in front of your ears?
Yes No Do you participate in sports in which injury to the face or teeth may occur? Describe _____
Yes No Have you had prolonged bleeding following extractions in the past?
Yes No Do you have concerns about receiving dental care? To what extent? Dread it___ Worry about it___ Don't mind it___
Yes No Have you had recent dental x-rays? When? _____ Where? _____

Women Only

Yes No Are you pregnant?
Yes No Are you taking birth control pills?

(Over for patient medical history)

PATIENT MEDICAL HISTORY

Yes No Have you within the past year, been under the care of a physician? If so, when and what for?_____

_____

Physician_____ City _____ Phone ( ) _____

Yes No Are you taking any medication now?

List current medications and the reason you're taking them: _____

_____

_____

_____

Indicate which of the following you have had or have at present. Circle "Yes" or "No"

Heart Failure	Yes	No	Emphysema	Yes	No	Hepatitis	Yes	No
Heart Disease or Attack	Yes	No	Cough	Yes	No	Anemia	Yes	No
Angina Pectoris	Yes	No	Tuberculosis (TB)	Yes	No	Liver Disease	Yes	No
High Blood Pressure	Yes	No	Asthma	Yes	No	Yellow Jaundice	Yes	No
Heart Murmur	Yes	No	Hay Fever	Yes	No	Blood Transfusion	Yes	No
Rheumatic Fever	Yes	No	Sinus Trouble	Yes	No	Drug Addiction	Yes	No
Mitral Valve Prolapse	Yes	No	Allergies or Hives	Yes	No	Hemophilia	Yes	No
Congenital Heart Lesions	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Artificial Heart Valve	Yes	No	Thyroid Disease	Yes	No	Stroke	Yes	No
Scarlet Fever	Yes	No	X-ray or Cobalt Treatment	Yes	No	Cold Sores	Yes	No
Heart Pacemaker	Yes	No	Chemotherapy	Yes	No	Fever Blister	Yes	No
Heart Surgery	Yes	No	Arthritis	Yes	No	Epilepsy or Seizures	Yes	No
Rheumatism	Yes	No	Fainting or Dizzy Spells	Yes	No	Cortisone Medicine	Yes	No
Sickle Cell Disease	Yes	No	Kidney Trouble	Yes	No	AIDS or HIV+	Yes	No
Glaucoma	Yes	No	Artificial Joints	Yes	No	Other	Yes	No
Ulcers	Yes	No	(Such as hip or knee)			Explain_____		

Yes No Have you ever had any major operations? If so, What?_____

Yes No Do you smoke? Packs per day?_____Number of Years?_____

Yes No Do you drink alcohol? How much per week?_____

Yes No Are you ever short of breath or do you have chest pain during mild exertion?

Yes No Do your ankles swell?

Yes No Have you recently gained or lost weight without dieting?

Yes No Is there a history of diabetes in your family?

Yes No Does your skin bruise easily?

Are you allergic or have you had any unusual reaction to any of the following:

Yes	No	Local Anesthetic (Novacaine)	Yes	No	Sulfa
Yes	No	Aspirin	Yes	No	Nitrous Oxide sedation
Yes	No	Codeine or other narcotics	Yes	No	Iodine
Yes	No	Penicillin	Yes	No	Barbiturates (sleeping pills)
Yes	No	Erythromycin	Yes	No	Latex (rubber)

Yes No Any other medications or materials? If so, please list them: _____

_____

Consent

The following information is not presented to worry you, but rather to conform to the principles of "INFORMED CONSENT". Any surgical procedure or anesthetic, no matter how small, may result in certain post-operative effects. Usually these effects are limited to swelling, discomfort, small amounts of bleeding and, less frequently, infection. On rare occasions anesthetic reactions may occur. When anesthesia or surgery is carried out on the lower jaw, there is a remote chance that prolonged numbness of the lower lip, chin and/or tongue may occur. While this numbness is almost always temporary, in exceptional cases it could be permanent. Other unlikely, but remotely possible occurrences include prolonged healing, injury to other teeth, broken jaw, and sinus infection. The utmost care will be taken so as to minimize the possibility of any of these complications. The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform, today and at future appointments, any and all forms of treatment, medication and therapy, that may be indicated.

Signature of Patient (or Parent/Guardian) _____Date_____