

PATIENT HISTORY

Acct. No. _____

INTRODUCTORY INFORMATION

Please Answer Each Question

Name _____ Date of Birth _____
Last First Middle Nickname

Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Residence Address _____ Home Phone () _____
Street City Zip

Employed By _____ Business Address _____
Street City Zip

Present Position _____ Occupation _____ How Long Held? _____

Business Phone () _____ Can we contact you at this number? Yes or No

Soc. Sec. Number _____ Driver's License Number _____

Spouse's Name _____ Soc. Sec. Number _____ Driver's Lic. Number _____

Spouse Employed By _____ Address _____
Street City Zip

Spouse's Present Position _____ Occupation _____ How Long Held? _____

Business Phone () _____ Can we contact you at this number? Yes or No

Financially Responsible Person _____
Last First Middle

Home Address _____ Home Phone () _____
Street City Zip

Employed By _____ Business Address _____
Street City Zip

Present Position _____ Occupation _____ How Long Held? _____

Business Phone () _____ Can we contact you at this number? Yes or No

Soc. Sec. Number _____ Driver's License Number _____

Relationship to Patient _____

Dental Insurance Carrier _____ Group Number or Plan _____

How did you first hear about this office? _____

Who may we contact in case of an emergency? _____

Once an appointment is made, please remember this time is reserved for you: at least 24 hours notice must be given if cancellation is absolutely necessary, otherwise cancellation charge will be made.

All accounts are due and payable at time service is rendered, unless prior arrangements have been made.

Finance charge of 1.5% per month will be charged if payment is 60 days late.

I have read the above and I understand that I am responsible for all charges incurred.

Signature

Date

MEDICAL HISTORY

CIRCLE

1. Are you having pain or discomfort at this time?YES NO
2. Do you feel very nervous about having dental treatment?YES NO
3. Have you ever had a bad experience in the dental office?YES NO
4. Have you been a patient in the hospital during the past two years?YES NO
5. Have you been under the care of a medical doctor during the past two years?YES NO
6. Have you taken any medicine or drugs during the past two years?YES NO
7. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications?YES NO
8. Have you ever had any excessive bleeding requiring special treatment?YES NO
9. Circle any of the following which you have had or have at present:

Heart Failure
Heart Disease or Attack
Angina Pectoris
High Blood Pressure
Heart Murmur
Rheumatic Fever
Congenital Heart Lesions
Scarlet Fever
Artificial Heart Valve
Mitral Valve Prolapse
Heart Pacemaker
Heart Surgery

Emphysema
Cough
Tuberculosis (TB)
Asthma
Hay Fever
Sinus Trouble
Allergies or Hives
Diabetes
Thyroid Disease

AIDS
Hepatitis A (infectious)
Hepatitis B (serum)
Liver Disease
Yellow Jaundice
Blood Transfusion
Drug Addiction
Hemophilia
Venereal Disease (Syphilis, Gonorrhea)
Cold Sores
Implant (breast, chin, etc.)
Genital Herpes
Epilepsy or Seizures
Fainting or Dizzy Spells
Nervousness
Psychiatric Treatment
Sickle Cell Disease
Bruise Easily

Artificial Joint
Anemia
Stroke
Kidney Trouble
Ulcers

X-ray or Cobalt Treatment
Chemotherapy (Cancer, Leukemia)
Arthritis
Rheumatism
Cortisone Medicine
Glaucoma
Pain in Jaw Joints

10. Have you taken Fen-Phen or ReduxYES NO
11. Have you been tested for H.I.V. VIRUS (AIDS)?YES NO
12. Are you aware of needing any premedication prior to dental treatment?YES NO
13. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?YES NO
14. Do your ankles swell during the day?YES NO
15. Do you use more than 2 pillows to sleep?YES NO
16. Have you ever lost or gained more than 10 pounds in the past year?YES NO
17. Do you ever wake up from sleep short of breath?YES NO
18. Are you on a special diet?YES NO
19. Has your medical doctor ever said you have a cancer or tumor?YES NO
20. Do you have any disease, condition, or problem not listed?YES NO
21. WOMEN: Are you pregnant now?YES NO
Are you practicing birth control?YES NO
Do you anticipate becoming pregnant?YES NO
22. Do you smoke?YES NO
23. Do you take aspirin or ibuprofen on a regular basis?YES NO
24. Are you allergic to latexYES NO
25. Do you drink alcoholic beverages? Daily _____ Weekly _____ Monthly _____

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 medicines change, I will inform the doctor of dentistry at the next appointment without fail. I hereby give permission to contact previous care givers.

Date

Signature of Patient, Parent or Guardian

COMMENTS

Date

Reviewed By