PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH _____

MALE: _____ FEMALE _____ PATIENT SOCIAL SECURITY #: _____

RESPONSIBLE PARTY NAME: (IF OTHER THAN PATIENT) _____

RESPONSIBLE PARTY SS#: (IF OTHER THAN PATIENT) _____

ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: _____ BUSINESS PHONE: _____

EMPLOYER: _____ INSURANCE PLAN: _____

SPOUSE NAME: _____ SPOUSE'S EMPLOYER: _____

Some dental plans require co-payments, or have some services that are not covered. In the event a co-payment is required does your spouse have a dental plan that also covers you?

SPOUSES DENTAL PLAN: _____ SS# _____

PLEASE COMPLETE & SIGN THE MEDICAL HISTORY ON THE BACK OF THIS PAGE

PATIENT MEDICAL - DENTAL HISTORY

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____

Date of last exam _____

Who referred you to our office? _____

	Yes	No
Are you under any medical treatment now?	☐	☐
Have you had any major operations? If so, what?	☐	☐
Have you ever had a serious accident involving head injuries?	☐	☐
Have you had any adverse response to any drugs including penicillin?	☐	☐
Has a Physician ever informed you that you had: A heart ailment (heart murmur, mitral valve prolapse)?	☐	☐
High Blood Pressure?	☐	☐
Hip or joint replacement?	☐	☐
Respiratory disease?	☐	☐
Diabetes?	☐	☐
Rheumatic fever?	☐	☐
Rheumatism or arthritis?	☐	☐
Tumors or growths?	☐	☐
Any blood disease?	☐	☐
Any liver disease?	☐	☐
Any kidney disease?	☐	☐
Any stomach or intestinal disease?	☐	☐
Any venereal disease?	☐	☐
HIV?	☐	☐
Yellow jaundice or hepatitis?	☐	☐
Do you have night sweats accompanied by weight loss or cough?	☐	☐
Are you on a diet at this time?	☐	☐
Are you now taking drugs or medication?	☐	☐
Are you allergic to any know materials resulting - in hives, asthma, eczema, etc?	☐	☐
Are you in general good health at this time?	☐	☐
Have any wounds healed slowly or presented other complications?	☐	☐
Are you pregnant?	☐	☐
Do you have a history of fainting?	☐	☐

PATIENT DENTAL HISTORY

Do you have any unhealed injuries or inflamed area in or around your mouth?	☐	☐
Have you experienced any growth or sore spots in your mouth?	☐	☐
Does any part of your mouth hurt when clenched?	☐	☐
Have you ever had novocaine anesthetic?	☐	☐
Any reactions or allergic symptoms to novocaine?	☐	☐
Prolonged bleeding following extractions in the past?	☐	☐
Do your gums bleed?	☐	☐
Have you ever had instruction on the care of your gums?	☐	☐

When was your last full mouth X-RAY taken? _____ Where? _____

Any part of your mouth sore to pressures or irritants (cold, sweets, etc.)	☐	☐

If so locate _____

Signature _____ Date _____