

PATIENT INFORMATION

Please Print

Date \_\_\_\_\_

Name  Dr.  Mr.  Mrs.  Ms. \_\_\_\_\_

Child  Single  Married  Divorced  Widowed Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Ext. \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_

Spouse's Social Security # \_\_\_\_\_ Person Responsible for bill \_\_\_\_\_

Dental Insurance  Yes  No If Yes Group Carrier \_\_\_\_\_ Group # \_\_\_\_\_

Has any member of your family been treated in our office?  Yes  No Name \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Call in case of emergency \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Reason for visit \_\_\_\_\_

MEDICAL HEALTH

Name and address of Physician \_\_\_\_\_

Physician's phone # \_\_\_\_\_ Last complete physical? \_\_\_\_\_

Overall General Health  Excellent  Good  Fair  Poor Do you or anyone you know have a snoring problem?  Yes  No

Please check those conditions that now or have ever pertained to you:

- |                          |                          |   |                          |                          |
|--------------------------|--------------------------|---|--------------------------|--------------------------|
| Yes                      | No                       |   | Yes                      | No                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur or Congenital Heart Defect | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery or Heart Disease          | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever                         | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Pacemaker                         | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Blood Pressure High / Low      | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Problems                       | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                                | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease                          | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaundice or Liver Disease               | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis                               | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease                        | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV +                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia                              | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation treatment                     | <input type="checkbox"/> | <input type="checkbox"/> |

- |                          |                          |  |                          |                          |
|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Yes                      | No                       |  | Yes                      | No                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemical dependency                              | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent weight loss                               | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions or Epilepsy                          | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness or Fainting Spells                     | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke   | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung problems or Tuberculosis                    | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma   | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers   | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement                                | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Diseases, ie. Anemia                       | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Trouble                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Females only: Are you pregnant?                  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently under the care of a physician? | <input type="checkbox"/> | <input type="checkbox"/> |

Are you allergic or sensitive to:

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Codeine                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Demerol                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics like Novacain               |
| <input type="checkbox"/> | <input type="checkbox"/> | Other Drugs, Medicines, or Foods (list) _____ |

Are you presently taking Medication?

If Yes, please list and give reason for taking) \_\_\_\_\_

Other Medical Problems Not Listed Above? \_\_\_\_\_

DENTAL HEALTH

On a scale from 1-10 (10 being highest) what priority do you give your teeth? \_\_\_\_\_

Name and Address of former Dentist \_\_\_\_\_

When was your last visit? \_\_\_\_\_ What was done at that time? \_\_\_\_\_

- |                          |                          |  |                          |                          |                                  |                          |                                     |
|--------------------------|--------------------------|--|--------------------------|--------------------------|----------------------------------|--------------------------|-------------------------------------|
| Yes                      | No                       |  | Yes                      | No                       |                                  | Yes                      | No                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are your teeth sensitive to sweets? Temperature? | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any teeth removed?  | <input type="checkbox"/> | <input type="checkbox"/>            |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you notice popping in your jaw?               | <input type="checkbox"/> | <input type="checkbox"/> | Do your gums bleed or have pain? | <input type="checkbox"/> | <input type="checkbox"/>            |
|                          |                          |  |                          |                          |                                  | <input type="checkbox"/> | <input type="checkbox"/>            |
|                          |                          |  |                          |                          |                                  |                          | Do you clench or grind your teeth?  |
|                          |                          |  |                          |                          |                                  |                          | Have you had orthodontic treatment? |

PERMIT FOR TREATMENT

This is to certify that I, undersigned, consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated and I will assume responsibility for fees associated with those procedures.

Patient's (Parent's) Signature \_\_\_\_\_ Date \_\_\_\_\_