PATIENT INFORMATION FORM

☐ Mrs. ☐ Mr.

Patient's Name_____ ☐ Ms. ☐ Dr. Birthday _____Age_____

Home Address_____ Home # (____) _____

City _____State _____ Zip_____ Work # (____) _____

E-mail Address _____ Fax# (___) _____ Cell # (____) _____

Social Security No._____ Driver's License No._____

Current Medical Doctor_____ Phone # (_____) _____

Address_____City/St/zip_____

Employer_____ Pharmacy Name_____ Pharmacy Phone (____) _____

Who referred you here? _____General Dentist_____ Phone # (_____) _____

Reason for today's visit_____

Name of person to notify incase of emergency_____ ***Phone #*** *(____)* _____

DENTAL INSURANCE INFORMATION

If you have your dental card please have front desk photocopy it.

Primary	Secondary
Insurance Company_____	Insurance company_____
Address_____	Address_____
Phone# (____)_____	Phone# _____
Name of Insured_____	Name of Insured_____
Relationship to patient_____	Relationship to patient_____
Social Security # _____	Social Security# _____
D.O.B. _____Group# _____	D.O.B. _____Group#_____
Employer_____	Employer_____
Employers Phone#_____	Employers#_____

RESPONSIBLE PARTY IF OTHER THAN PATIENT

Person financially responsible_____ Home # (____) _____

Address_____ City/St/Zip_____

Social Security # _____ Driver's License #_____

Employer_____ Work # (____) _____

ASSIGNMENT AND RELEASE

I authorize and release any information necessary to process my or my dependant's claims and request payment or benefit paid directly to the doctor. I also agree that should the amount be insufficient to cover the entire expense I will be responsible for the difference. I will also be responsible for all bank charges, office charges, and collection charges if incurred. I herby authorize the dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures, as my by necessary for proper dental care. The information on this page and the medical/dental histories are correct to the best of my knowledge. I grant the right to the dentist to release my medical/ dental histories and other information about my dental treatment to third party pay or and/or health professionals.

Signature_____Date_____

(Patient/ Parent or Guardian)

HEALTH HISTORY ASA I II III IV

Do you consider yourself in good health? ..... ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No If yes, reason _____

Physicians name and phone number _____

Have you been in the hospital in the last 5 years? ☐ Yes ☐ No If yes, reason: _____

Have you ever had any of the following conditions?

CARDIOVASCULAR SYSTEM

High blood pressure..... ☐ Yes ☐ No
Congenital heart disease..... ☐ Yes ☐ No
Rheumatic fever..... ☐Yes ☐ No
Heart murmur..... ☐ Yes ☐ No
Heart Pacemaker..... ☐ Yes ☐ No
Vascular graft..... ☐ Yes ☐ No
Heart or bypass surgery..... ☐ Yes ☐ No
Heart attack..... ☐ Yes ☐ No
Congestive heart failure ..... ☐ Yes ☐ No
Awaken with breathing difficulty ..... ☐ Yes ☐ No
Angina pectoris/chest pain ..... ☐ Yes ☐ No
Swollen ankles ..... ☐ Yes ☐ No
Irregular or rapid heartbeats..... ☐ Yes ☐ No
Stroke ..... ☐ Yes ☐ No

RESPIRATORY SYSTEM

Emphysema or asthma.....☐ Yes ☐ No
History of Nose Bleeds ..... ☐ Yes ☐ No
Chronic cough or bronchitis ..... ☐ Yes ☐ No
Chronic sinusitis..... ☐ Yes ☐ No
Breathing Problems ..... ☐ Yes ☐ No

MUSCULO-SKELETAL/CNS/DEVELOPMENTAL

Frequent headaches ☐ Yes ☐ No
Fainting spells or loss of consciousness ☐ Yes ☐ No
Seizures or epilepsy ☐ Yes ☐ No
Visual impairment/ Glaucoma ..... ☐ Yes ☐ No
Hearing impairment..... ☐ Yes ☐ No
Artificial Joint..... ☐ Yes ☐ No
Arthritis or bone disease..... ☐ Yes ☐ No
Muscle Disease..... ☐ Yes ☐ No
Spinal cord injury or paralysis ..... ☐ Yes ☐ No
Cerebral palsy ..... ☐ Yes ☐ No
Mental retardation/ Autism..... ☐ Yes ☐ No
Alzheimer's disease or other dementia..... ☐ Yes ☐ No

HEMATOLOGIC/ENDOCRINE/IMMUNE

Blood Transfusion..... .....☐ Yes ☐ No
Denied permission to give blood .....☐ Yes ☐ No
Anemia/ Leukemia/ Lymphoma..... .....☐ Yes ☐ No
Hemophilia . .....☐ Yes ☐ No
Sickle Cell Disease.....☐ Yes ☐ No
Blood Clots . .....☐ Yes ☐ No
Diabetes ....☐ Yes ☐ No
Thyroid..... .....☐ Yes ☐ No
Adrenal Gland Disease .....☐ Yes ☐ No
AIDS .....☐ Yes ☐ No
HIV Infection.....☐ Yes ☐ No
Bleeding or bruising tendency.....☐ Yes ☐ No
Sudden weight loss or gain .....☐ Yes ☐ No
Frequent thirst .....☐ Yes ☐ No
Frequent hunger ....☐ Yes ☐ No
Frequent urination ....☐ Yes ☐ No
Cancer/Radiotherapy/Chemotherapy . .....☐ Yes ☐ No
Systemic Lupus ....☐ Yes ☐ No
Tuberculosis (TB)..... .....☐ Yes ☐ No

GASTROINTESTINAL/GENITOURINARY

Colitis or ulcers ....☐ Yes ☐ No
Hepatitis or other liver disease..... .....☐ Yes ☐ No
Jaundice ....☐ Yes ☐ No
Renal dialysis/transplant..... .....☐ Yes ☐ No
Kidney disease ....☐ Yes ☐ No
Frequent canker sores..... .....☐ Yes ☐ No
Frequent vomiting ....☐ Yes ☐ No
Chronic diarrhea..... .....☐ Yes ☐ No

ALLERGIES

Penicillin/ Sulfa drugs..... .....☐ Yes ☐ No
Novocain/ Lidocaine ....☐ Yes ☐ No
Dental Anesthetics ....☐ Yes ☐ No
Aspirin/ Codeine..... .....☐ Yes ☐ No
Latex products..... .....☐ Yes ☐ No
Iodine.....☐ Yes ☐ No
Other, Please List_____ ☐ Yes ☐ No

PSYCHIATRIC

Nervous ..... ☐ Yes ☐ No
Depression ..... ☐ Yes ☐ No
Past/present psychiatric treatment..... ☐ Yes ☐ No

FAMILY HISTORY (Grandparents, Siblings, Children)

Diabetes ..... ☐ Yes ☐ No
Heart Disease ..... ☐ Yes ☐ No
Bleeding Disorders ..... ☐ Yes ☐ No

FEMALES

Are you pregnant now? ..... ☐ Yes ☐ No
Do you anticipate becoming pregnant? ..... ☐ Yes ☐ No
Are you on birth control ..... ☐ Yes ☐ No

If yes, how many months_____
Are you breast-feeding..... ☐ Yes ☐ No
Heavy menstrual bleeding..... ☐ Yes ☐ No

Do you now or have you ever taken any of the following medications?

Anticoagulants ..... ☐ Yes ☐ No
Tranquilizers ..... ☐ Yes ☐ No
Heart medication ..... ☐ Yes ☐ No
Nitroglycerin ..... ☐ Yes ☐ No
Antidepressants ..... ☐ Yes ☐ No

Insulin ..... ☐ Yes ☐ No
Cortisone (Steroids) ..... ☐ Yes ☐ No
Blood Pressure Medications ..... ☐ Yes ☐ No
Aspirin..... ☐ Yes ☐ No
Phen–Fen... ☐ Yes ☐ No

Do you now or have you ever used recreational drugs?..... ☐ Yes ☐ No
Past or current history of drug addiction ..... ☐ Yes ☐ No

Please list all current medications: _____ _____ _____

SOCIAL HISTORY

Do you use tobacco?..... ☐ Yes ☐ No
What kind? _____
How Much? _____
explain_____
How many years? _____

Do you drink alcoholic beverages? ..... ☐ Yes ☐ No
What kind? _____
How much per day? _____
How long? _____

DENTAL HISTORY

Are you having pain or discomfort related to your mouth?..... ☐ Yes ☐ No
If yes, please _____
_____
Nervous about having Dental treatment?..... ☐ Yes ☐ No
Have you ever had a bad experience in a dental office?..... ☐ Yes ☐ No
Periodontal surgery?..... ☐ Yes ☐ No

Do you have any other conditions not already mentioned? ☐ Yes ☐ No If yes, please list: _____

***To the best of my knowledge, all of the preceding information is correct*.**

SIGNATURE_____ DATE_____
(Patient/ Parent or Guardian)

FOR OFFICE USE ONLY

MEDICAL CONDITIONS	MEDICATIONS	TREATMENT MODIFICATIONS

Medical History Update:

Date	Change	Patient Signature
Date	Change	Patient Signature
Date	Change	Patient Signature