

## PATIENT INFORMATION AND HEALTH HISTORY

### INITIAL EXAM

DATE \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
SINGLE MARRIED LONG TERM PARTNER DIVORCED SEPARATED WIDOWED

PATIENT'S ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ PATIENT'S SS# \_\_\_\_\_

DENTAL INSURANCE PLAN (IF ANY) \_\_\_\_\_ REFERRED BY \_\_\_\_\_

PATIENT'S NAME

### DENTAL HISTORY

CHIEF ORAL COMPLAINT \_\_\_\_\_

DATE OF LAST DENTAL EXAM. \_\_\_\_\_ ANY PREVIOUS MAJOR DENTAL TREATMENT,  YES  NO WHEN \_\_\_\_\_

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Teeth sensitive to cold, heat, sweets or pressure | <input type="checkbox"/> Bad breath                           | <input type="checkbox"/> Cigarettes, pipe or cigar smoking |
| <input type="checkbox"/> Bleeding gums. How long _____                     | <input type="checkbox"/> Unpleasant taste                     | <input type="checkbox"/> Texture of toothbrush _____       |
| <input type="checkbox"/> Food impaction                                    | <input type="checkbox"/> Unfavorable dental experience        | <input type="checkbox"/> Frequency of brushing _____       |
| <input type="checkbox"/> Clenching or grinding                             | <input type="checkbox"/> Complications from extractions       | <input type="checkbox"/> Dental Floss                      |
| <input type="checkbox"/> Burning of tongue                                 | <input type="checkbox"/> Periodontal treatment                | <input type="checkbox"/> Inter dental stimulators          |
| <input type="checkbox"/> Swelling or lumps in mouth                        | <input type="checkbox"/> Orthodontic treatment                | <input type="checkbox"/> Water jet device                  |
| <input type="checkbox"/> Frequent blisters on lips or mouth                | <input type="checkbox"/> Mouth breathing                      | <input type="checkbox"/> Disclosing tablets or solution    |
| <input type="checkbox"/> Pain around ear                                   | <input type="checkbox"/> Oral habits, i.e., fingernail biting | <input type="checkbox"/> Fluoride supplements              |
| <input type="checkbox"/> Unusual sounds in ear while eating                | <input type="checkbox"/> cheek biting, etc.                   | <input type="checkbox"/> Alcohol                           |

### MEDICAL HISTORY

PHYSICIAN'S NAME \_\_\_\_\_ DATE OF LAST PHYSICAL EXAM. \_\_\_\_\_ AGE \_\_\_\_\_

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Allergies to drugs                        | <input type="checkbox"/> Asthma                              | <input type="checkbox"/> Immune System Disorders (AIDS, HIV, ARC) |
| <input type="checkbox"/> Allergies to anesthetics                  | <input type="checkbox"/> Hay fever or allergies in general   | <input type="checkbox"/> Stroke                                   |
| <input type="checkbox"/> Any heart ailments                        | <input type="checkbox"/> Diabetes                            | <input type="checkbox"/> Thyroid                                  |
| <input type="checkbox"/> High blood pressure                       | <input type="checkbox"/> Kidney problems                     | <input type="checkbox"/> Eye disorders                            |
| <input type="checkbox"/> Neurological problems                     | <input type="checkbox"/> Latex sensitivity                   | <input type="checkbox"/> Tonsillitis                              |
| <input type="checkbox"/> Radiation treatments                      | <input type="checkbox"/> Liver problems or hepatitis         | <input type="checkbox"/> Tuberculosis                             |
| <input type="checkbox"/> Excessive bleeding from cut or extraction | <input type="checkbox"/> Malignancies                        | <input type="checkbox"/> Ulcer or colitis                         |
| <input type="checkbox"/> Anemia or blood problems                  | <input type="checkbox"/> Psychiatric care/emotional problems | <input type="checkbox"/> Pregnancy If so, what month _____        |
| <input type="checkbox"/> Arthritis                                 | <input type="checkbox"/> Rheumatic fever                     | <input type="checkbox"/> Venereal disease                         |
| <input type="checkbox"/> Chronic Fatigue Syndrome                  | <input type="checkbox"/> Sinus problems                      | <input type="checkbox"/> Other _____                              |

Describe any current medical treatment including drugs taken, even though not listed above \_\_\_\_\_

**APPOINTMENTS:** A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

**INSURANCE:** To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)