

PATIENT INFORMATION

CONFIDENTIAL

PATIENT LAST NAME:

PREFERRED LANGUAGE: ENGLISH SPANISH KOREAN OTHER _____ DATE _____

NAME _____ BIRTHDATE _____ HOME PHONE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-MAIL _____ CELL PHONE _____

CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

PATIENT NUMBER#

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ FINANCIAL INSTITUTION _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS# _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS# _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

X _____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

SIGNATURE

PATIENT INFORMATION CONTINUED

PATIENT NAME: _____

DATE OF BIRTH: _____

PATIENT LAST NAME: _____

PATIENT MEDICAL HISTORY

PHYSICIAN: _____ OFFICE PHONE: _____ DATE OF LAST EXAM: _____

1. ARE YOU UNDER MEDICAL TREATMENT NOW? YES NO

2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGERY OR SERIOUS ILLNESS? YES NO

3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? YES NO
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____

4. HAVE YOU EVER TAKEN BISPHOSPHONATES? YES NO

5. DO YOU USE TOBACCO? YES NO

6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS? YES NO

7. ARE YOU WEARING CONTACT LENSES? YES NO

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

YES NO	YES NO	YES NO
<input type="checkbox"/> LOCAL ANESTHETICS (E.G. NOVOCAINE)	<input type="checkbox"/> BARBITURATES	<input type="checkbox"/> ASPIRIN
<input type="checkbox"/> PENICILLIN OR OTHER ANTIBIOTICS	<input type="checkbox"/> SEDATIVES	<input type="checkbox"/> LATEX
<input type="checkbox"/> SULFA DRUGS	<input type="checkbox"/> IODINE	<input type="checkbox"/> OTHER

9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)? YES NO

10. WOMEN ONLY:

A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? YES NO

B) ARE YOU NURSING? YES NO

C) ARE YOU TAKING BIRTH CONTROL PILLS? YES NO

11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

<p>YES NO</p> <p><input type="checkbox"/> HIGH BLOOD PRESSURE</p> <p><input type="checkbox"/> HEART ATTACK</p> <p><input type="checkbox"/> RHEUMATIC FEVER</p> <p><input type="checkbox"/> SWOLLEN ANKLES</p> <p><input type="checkbox"/> FAINTING / SEIZURES</p> <p><input type="checkbox"/> ASTHMA</p> <p><input type="checkbox"/> LOW BLOOD PRESSURE</p> <p><input type="checkbox"/> EPILEPSY / CONVULSIONS</p> <p><input type="checkbox"/> LEUKEMIA</p> <p><input type="checkbox"/> DIABETES</p> <p><input type="checkbox"/> KIDNEY DISEASES</p> <p><input type="checkbox"/> AIDS OR HIV INFECTION</p> <p><input type="checkbox"/> THYROID PROBLEM</p>	<p>YES NO</p> <p><input type="checkbox"/> HEART DISEASE</p> <p><input type="checkbox"/> CARDIAC PACEMAKER</p> <p><input type="checkbox"/> HEART MURMUR</p> <p><input type="checkbox"/> ANGINA</p> <p><input type="checkbox"/> FREQUENTLY TIRED</p> <p><input type="checkbox"/> ANEMIA</p> <p><input type="checkbox"/> EMPHYSEMA</p> <p><input type="checkbox"/> CANCER</p> <p><input type="checkbox"/> ARTHRITIS</p> <p><input type="checkbox"/> JOINT REPLACEMENT OR IMPLANT</p> <p><input type="checkbox"/> HEPATITIS / JAUNDICE</p> <p><input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE</p> <p><input type="checkbox"/> STOMACH TROUBLES / ULCERS</p>	<p>YES NO</p> <p><input type="checkbox"/> CHEST PAINS</p> <p><input type="checkbox"/> EASILY WINDED</p> <p><input type="checkbox"/> STROKE</p> <p><input type="checkbox"/> HAY FEVER / ALLERGIES</p> <p><input type="checkbox"/> TUBERCULOSIS</p> <p><input type="checkbox"/> RADIATION THERAPY</p> <p><input type="checkbox"/> GLAUCOMA</p> <p><input type="checkbox"/> RECENT WEIGHT LOSS</p> <p><input type="checkbox"/> LIVER DISEASE</p> <p><input type="checkbox"/> HEART TROUBLE</p> <p><input type="checkbox"/> RESPIRATORY PROBLEMS</p> <p><input type="checkbox"/> OTHER _____</p>
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COMMENTS

SIGNATURE OF DENTIST _____ DATE _____

PATIENT DENTAL HISTORY

<p>1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?</p> <p style="padding-left: 20px;">A) CLICKING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 20px;">B) PAIN (JOINT, EAR, SIDE OF FACE)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 20px;">C) DIFFICULTY IN OPENING OR CLOSING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 20px;">D) DIFFICULTY IN CHEWING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>8. DO YOU HAVE FREQUENT HEADACHES? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>9. DO YOU CLENCH OR GRIND YOUR TEETH? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>12. HAVE YOU HAD ANY ORTHODONTIC WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
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SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X

PATIENT, PARENT OR GUARDIAN

DATE

HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____

GOOGLE YELP FACEBOOK FRIEND DOCTOR