

# PATIENT INFORMATION

CONFIDENTIAL

PATIENT # \_\_\_\_\_

(PLEASE PRINT)

DATE \_\_\_\_\_

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
FIRST MI LAST

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_

E-MAIL \_\_\_\_\_ CELL PHONE \_\_\_\_\_

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED  
PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_  
SPOUSE OR PARENT/GUARDIAN'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

PERSON TO CONTACT IN CASE OF AN EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_

## 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 #/SIN \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS OF EMPLOYER \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ GROUP # \_\_\_\_\_ UNION OR LOCAL # \_\_\_\_\_

INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_

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 #/SIN \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS OF EMPLOYER \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ GROUP # \_\_\_\_\_ UNION OR LOCAL # \_\_\_\_\_

INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_

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

X

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

SIGNATURE

PATIENT NAME \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

HOME PHONE \_\_\_\_\_

E-MAIL \_\_\_\_\_

CELL PHONE \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

BUSINESS PHONE \_\_\_\_\_

SS #/SIN \_\_\_\_\_

## PATIENT MEDICAL HISTORY

PHYSICIAN _____	OFFICE PHONE _____	DATE OF LAST EXAM _____
	YES NO	

1. ARE YOU UNDER MEDICAL TREATMENT NOW? ☐ YES ☐ NO

2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION 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 FEN-PHEN/REDUX? ☐ 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 (EG. NOVOCAINE)	<input type="checkbox"/> BARBITURATES	<input type="checkbox"/> ASPIRIN
<input type="checkbox"/> PENICILLIN OR OTHER ANTIBIOTICS	<input type="checkbox"/> SEDATIVES	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> SULFA DRUGS	<input type="checkbox"/> IODINE	

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

## II. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

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

## COMMENTS

SIGNATURE OF DENTIST \_\_\_\_\_

DATE \_\_\_\_\_

## PATIENT DENTAL HISTORY

YES NO	YES NO
--------	--------

1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? ☐ YES ☐ NO

2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? ☐ YES ☐ NO

3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? ☐ YES ☐ NO

4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? ☐ YES ☐ NO

5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? ☐ YES ☐ NO

6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? ☐ YES ☐ NO

7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?

A) CLICKING? ☐ YES ☐ NO

B) PAIN (JOINT, EAR, SIDE OF FACE)? ☐ YES ☐ NO

C) DIFFICULTY IN OPENING OR CLOSING? ☐ YES ☐ NO

D) DIFFICULTY IN CHEWING? ☐ YES ☐ NO

8. DO YOU HAVE FREQUENT HEADACHES? ☐ YES ☐ NO

9. DO YOU CLENCH OR GRIND YOUR TEETH? ☐ YES ☐ NO

10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? ☐ YES ☐ NO

11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST? ☐ YES ☐ NO

12. HAVE YOU HAD ANY ORTHODONTIC WORK? ☐ YES ☐ NO

13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS? ☐ YES ☐ NO

14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? ☐ YES ☐ NO

15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS? ☐ YES ☐ NO

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 \_\_\_\_\_