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PATIENT INFORMATION AND HEALTH HISTORY

Date _____
Patient's Name_____ Date of Birth _____
☐ Male ☐ Female
Patient's Address_____
Street City State Zip Code
Home Phone _____ Cell Phone _____
Work Phone _____ Email_____
Patient Social Security Number_____ Drivers License Number _____
Patient's Employer _____
Dental Insurance Plan (if any) _____Group Number _____
Subscriber's Name _____Subscriber's Birthday _____
Subscriber's ID _____ How did you hear about us?_____

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 (✓)

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

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 (✓)

- ☐ Prescribed blood thinners
- ☐ Require a pre-med
- ☐ Allergies to drugs List _____
- ☐ Allergies to anesthetics
- ☐ Heart Attack Date? _____
- ☐ Any heart ailments Describe_____
- ☐ Pacemaker When was it placed? _____
- ☐ Stents When placed? _____
- ☐ High blood pressure
- ☐ Neurological problems
- ☐ Radiation treatments
- ☐ Excessive bleeding from cut or extraction
- ☐ Anemia or blood problems
- ☐ Arthritis
- ☐ Any artificial or replaced joints i.e. knees, hips, etc.
- ☐ Asthma
- ☐ Hay fever or allergies in general
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Liver problems or hepatitis
- ☐ Malignancies
- ☐ Psychiatric care/emotional problems
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Immune System Disorders (AIDS, HIV, ARC)
- ☐ Stroke
- ☐ Thyroid
- ☐ Eye disorders
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer or colitis
- ☐ Pregnancy What month?_____
- ☐ Venereal disease
- ☐ Other _____

Describe any current medical treatment including drugs taken _____
_____

*APPOINTMENTS: A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. Once an appointment is made, please remember this time has been reserved for you.
*INSURANCE: We wish our patients to know that all 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, upon receipt of full payment of bill. We do not render our services on the basis that insurance companies will pay all our fees.

SIGNATURE_____ DATE_____
(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

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Employee signature: *Date:*

This form does not constitute legal advice and covers only federal, not state, law.