

PATIENT HEALTH HISTORY & INFORMATION

Today's Date: _____

NAME: _____ Sex: M F Marital Status: Single Married Divorced Other
Last First

ADDRESS (Home): _____ Home Phone#:() _____
Street City Zip

Date of Birth: _____ Social Security# _____ Drivers License# _____

Work Phone #() _____ Cell #() _____ E-Mail _____

Employer: _____ City and State _____ Occupation: _____

Spouses Name: _____ Social Security _____ Date of Birth _____
Identification number _____ Phone #() _____ Employer: _____
Work Phone #() _____

Nearest Relative in area not living with you _____ Phone# () _____

Who can we thank for referring you to this office _____

INSURANCE INFORMATION

Subscriber name: _____ Home and/or Cell# () _____
Name of Insurance Company _____ Policy/Group # _____
Subscribers Employer: _____ Work Phone: () _____
Social Security# _____ Date of Birth: _____

ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor, or qualified designate. I have received a copy of the **Dental Materials Fact Sheet** as required by law.

I also acknowledge full responsibility for my payment and agree to pay, in full, **AT THE TIME OF SERVICE**, unless other arrangements are made with the Financial Department. Signed _____

Patient, Parent or Guardian (Must be 18 years or older)

MEDICAL / DENTAL HISTORY

Physician's name: _____ City/State _____ Phone# () _____

When did you last consult physician? _____ Reason: _____

Have you been hospitalized within the past 5 years: Yes No Reason: _____

Name of former dentist: _____ Date of last dental examination: _____

Purpose of today's visit: complete examination pain broken tooth other: _____

Do you have, or did you have any of the following (Please check and describe fully under remarks):

YES NO		YES NO		YES NO	
Heart Disease.....	<input type="checkbox"/> <input type="checkbox"/>	11. Psychiatric Treatment.....	<input type="checkbox"/> <input type="checkbox"/>	21. Allergies.....	<input type="checkbox"/> <input type="checkbox"/>
High Blood Pressure.....	<input type="checkbox"/> <input type="checkbox"/>	12. Arthritis.....	<input type="checkbox"/> <input type="checkbox"/>	a. medications.....	<input type="checkbox"/> <input type="checkbox"/>
Blood disorder - anemia.....	<input type="checkbox"/> <input type="checkbox"/>	13. Tumor History.....	<input type="checkbox"/> <input type="checkbox"/>	b. latex.....	<input type="checkbox"/> <input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/> <input type="checkbox"/>	14. Venereal Disease.....	<input type="checkbox"/> <input type="checkbox"/>	22. Asthma.....	<input type="checkbox"/> <input type="checkbox"/>
Heart Murmur.....	<input type="checkbox"/> <input type="checkbox"/>	15. Sinus Trouble.....	<input type="checkbox"/> <input type="checkbox"/>	23. Tuberculosis, Emphysema.....	<input type="checkbox"/> <input type="checkbox"/>
Thyroid disease, hyperthyroidism.....	<input type="checkbox"/> <input type="checkbox"/>	16. Ulcers.....	<input type="checkbox"/> <input type="checkbox"/>	24. Artificial joints.....	<input type="checkbox"/> <input type="checkbox"/>
Diabetes.....	<input type="checkbox"/> <input type="checkbox"/>	17. Radiation Treatment.....	<input type="checkbox"/> <input type="checkbox"/>	25. History of Phen Phen.....	<input type="checkbox"/> <input type="checkbox"/>
Stroke.....	<input type="checkbox"/> <input type="checkbox"/>	18. Liver or Kidney Disease.....	<input type="checkbox"/> <input type="checkbox"/>	26. Pacemaker.....	<input type="checkbox"/> <input type="checkbox"/>
Epilepsy.....	<input type="checkbox"/> <input type="checkbox"/>	19. Hepatitis, Jaundice.....	<input type="checkbox"/> <input type="checkbox"/>	27. Are you pregnant?.....	<input type="checkbox"/> <input type="checkbox"/>
Fainting.....	<input type="checkbox"/> <input type="checkbox"/>	20. AIDS/HIV +.....	<input type="checkbox"/> <input type="checkbox"/>	28. Do you smoke or drink alcohol?.....	<input type="checkbox"/> <input type="checkbox"/>
				29. Cancer.....	<input type="checkbox"/> <input type="checkbox"/>

Have you had excessive bleeding requiring treatment?.....

Are you taking any medicines, drugs, or pills?.....

Have you experienced any unfavorable reaction to previous dental treatment?.....

Do you have any disease, condition or problem not listed above that you think I should know about? _____

Patient Signature: _____ Date: _____ Doctor Signature: _____ Date: _____

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