

# 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 \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
SPOUSE OR PARENT/GUARDIAN'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
STATE/PROV. \_\_\_\_\_

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 \_\_\_\_\_  
 HOME ADDRESS \_\_\_\_\_  
 \_\_\_\_\_  
 E-MAIL \_\_\_\_\_  
 BUSINESS ADDRESS \_\_\_\_\_  
 \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_  
 DATE OF BIRTH \_\_\_\_\_  
 HOME PHONE \_\_\_\_\_  
 CELL PHONE \_\_\_\_\_  
 BUSINESS PHONE \_\_\_\_\_  
 SS #/SIN \_\_\_\_\_

**PATIENT MEDICAL HISTORY**

PHYSICIAN \_\_\_\_\_ OFFICE PHONE \_\_\_\_\_ DATE OF LAST EXAM \_\_\_\_\_

	YES	NO			
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	<input type="checkbox"/>	<input type="checkbox"/>	8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?	YES	NO
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	<input type="checkbox"/>	<input type="checkbox"/>	YES NO	YES NO	YES NO
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> LOCAL ANESTHETICS (E.G. NOVOCAINE)	<input type="checkbox"/> BARBITURATES	<input type="checkbox"/> ASPIRIN
4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> PENICILLIN OR OTHER ANTIBIOTICS	<input type="checkbox"/> SEDATIVES	<input type="checkbox"/> OTHER _____
5. DO YOU USE TOBACCO?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> SULFA DRUGS	<input type="checkbox"/> IODINE	
6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	<input type="checkbox"/>	<input type="checkbox"/>	9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)?	YES	NO
7. ARE YOU WEARING CONTACT LENSES?	<input type="checkbox"/>	<input type="checkbox"/>	10. WOMEN ONLY:	<input type="checkbox"/>	<input type="checkbox"/>
			A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>
			B) ARE YOU NURSING?	<input type="checkbox"/>	<input type="checkbox"/>
			C) ARE YOU TAKING BIRTH CONTROL PILLS?	<input type="checkbox"/>	<input type="checkbox"/>

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**

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

**PATIENT DENTAL HISTORY**

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

**SIGNATURE**

X

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.

PATIENT, PARENT OR GUARDIAN

DATE