

Patient Name:

Account #:

Patient Code:

Date:

Patient, Pharmacy and Insurance Information

Patient Information

Prefix: _____ First Name: _____ Middle Name: _____ Last Name: _____

Suffix: _____

Street: _____ Zip: _____ City: _____ State: _____ Country: _____

Preferred Phone #: _____ Is this a mobile number? Yes No

Email Address: _____

Date of Birth: _____ Sex: Male Female Unspecified

Emergency Contact: _____ Emergency Phone #: _____

Primary Language: English Spanish Other: _____

Responsible Party

First Name: _____ Middle Name: _____ Last Name: _____

Street: _____ Zip: _____ City: _____ State: _____ Country: _____

Date of Birth: _____ Sex: Female Male Unspecified

Responsible Party Signature: _____ Date: _____

Preferred Pharmacy

Name: _____ Phone Number: _____

Street: _____ Zip: _____ City: _____ State: _____

Primary Dental Insurance

Is subscriber the same as patient? Yes No

Subscriber Information:

First Name: _____ Middle Name: _____ Last Name: _____

Employer Name: _____ Insurance Company: _____

Ins Phone Number: _____

Subscriber ID/Policy Number: _____ Group/Contract Number: _____ Date of Birth: _____

Patient Relationship to Subscriber: Child Disabled Dependent Husband Self Wife Other Dependent

Subscriber SSN: _____

Secondary Dental Insurance

Is subscriber the same as patient? Yes No

Subscriber Information:

First Name: _____ Middle Name: _____ Last Name: _____

Employer Name: _____ Insurance Company: _____

Ins Phone Number: _____

Subscriber ID/Policy Number: _____ Group/Contract Number: _____ Date of Birth: _____

Patient Relationship to Subscriber: Child Disabled Dependent Husband Self Wife Other Dependent

Subscriber SSN: _____

Health History

Reason for Visit: Broken Tooth Check-up Cosmetic Dentures Tooth Pain Other: _____

Height: _____ ft _____ in Weight: _____ Patient Date of Birth: _____

Are you under the care of a primary physician? Yes No

Primary Physician's Name: _____ Physician's Phone Number: _____

Date of Last Physical:

I don't know exact date Last 6 months 6 months - 1 year 1-3 years Greater than 4 years Never Other: _____

Are you taking or have you taken any steroid/cortisone therapy in the last 2 years? Yes No

Have you ever been hospitalized? Yes No

Are you taking or have you taken Oral Bisphosphonates (e.g., FOSAMAX, BONIVA) or IV Bisphosphonates, (e.g., ZOMETA, AREDIA)?

No Yes How Long? _____

Do you require antibiotics prior to dental procedures? Yes No

Are you allergic or have you had an adverse reaction to any of the following?

None Amoxicillin Aspirin Codeine Epinephrine Latex Metals Novocain Penicillin Sulfa Tetracycline

Other: _____

List any medications you are taking including non-prescription drugs and herbals/vitamins:

None

Check any conditions that apply to you:

- | | | |
|---|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> NON-DENTAL Implants
Type: _____ |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Organ Transplants
Type: _____ |
| <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pace Maker |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Artificial Joint/Pins
Type: _____
Age: _____ | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiosurgery |
| <input type="checkbox"/> Aspirin Therapy | <input type="checkbox"/> Heart Surgery
Date: _____ | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Trouble
Type: _____ | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Hepatitis
Type: _____ | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> HIV | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Cancer
Type: _____ | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Coumadin Therapy | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tuberculosis(TB) |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Lung Disease/COPD | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes
Type: _____ | <input type="checkbox"/> Lupus | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Other Disease/Illness
Type: _____ |
| | <input type="checkbox"/> Mobility Impairment | _____ |

Dental History

Date of Last Dental Visit:

 I don't know exact date Last 6 months 6 months - 1 year 1-3 years Greater than 4 years Never Other: _____

Date of Last Dental X-ray:

 I don't know exact date Last 6 months 6 months - 1 year 1-3 years Greater than 4 years Never Other: _____**Oral Health**Have you ever been treated for periodontal (gum) disease? Yes NoHave you ever had Novocaine or other local anesthetic? Yes No

How happy are you with your smile (1-10)? _____

Are you currently wearing Dentures? Yes NoAge of dentures: Less Than 6 Months 6 months-3 years Greater than 4 years

Please check any conditions that apply to you below:

Pain In Jaw(TMJ) Teeth Grinding/Clenching Use Tobacco Products Mouth Sores
 Sensitive Teeth Broken/Loose Teeth Difficulty Chewing/Swallowing Swollen/Bleeding Gums

Women Patients OnlyAre you currently pregnant? Yes No Estimated Delivery Date: _____Are you Nursing? Yes No Are you taking any birth control prescriptions? Yes No

**NOTE Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature: _____ Date: _____

Dr's Signature/Medical History Review: _____ Date: _____

6 MONTH UPDATE

Patient's Signature: _____ Date: _____

Dr's Signature/Medical History Review: _____ Date: _____