

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 \_\_\_\_\_

1. ARE YOU UNDER MEDICAL TREATMENT NOW?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	YES <input type="checkbox"/>	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"/>		
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____			SULFA DRUGS <input type="checkbox"/>	IODINE <input type="checkbox"/>						
4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	YES <input type="checkbox"/>	NO <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 <input type="checkbox"/>	NO <input type="checkbox"/>					
5. DO YOU USE TOBACCO?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	10. WOMEN ONLY:							
6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	YES <input type="checkbox"/>	NO <input type="checkbox"/>					
7. ARE YOU WEARING CONTACT LENSES?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	B) ARE YOU NURSING?	YES <input type="checkbox"/>	NO <input type="checkbox"/>					
			C) ARE YOU TAKING BIRTH CONTROL PILLS?	YES <input type="checkbox"/>	NO <input type="checkbox"/>					

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

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

**COMMENTS**

---



---



---



---



---



---

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** \_\_\_\_\_

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** \_\_\_\_\_ DATE \_\_\_\_\_

PATIENT, PARENT OR GUARDIAN

# PATIENT INFORMATION

CONFIDENTIAL

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

(PLEASE PRINT)

DATE \_\_\_\_\_

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

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

BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ WORK PHONE STATE/ZIP/PROV. P.C. \_\_\_\_\_

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

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

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

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

INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/ZIP/PROV. 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 INFORMATION

CONFIDENTIAL

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

(PLEASE PRINT)

DATE \_\_\_\_\_

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

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

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

CHECK APPROPRIATE BOX:  MINOR  SINGLE  MARRIED  DIVORCED  WIDOWED  SEPARATED  
PATIENT'S OR

PARENT/GUARDIAN'S EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

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

SPOUSE OR PARENT/GUARDIAN'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

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/ZIP/PROV. P.C. \_\_\_\_\_

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

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

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

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