# PATIENT INFORMATION AND HEALTH HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

SINGLE MARRIED DIVORCED SEPARATED WIDOWED

PATIENT'S ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP CODE _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____

EMPLOYED BY _____ BUSINESS PHONE _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ REFERRED BY _____

## DENTAL HISTORY

S.S.N. _____

CHIEF ORAL COMPLAINT _____

DATE OF LAST DENTAL EXAM. _____

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 _____
- ☐ Clenching or grinding
- ☐ 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

## 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 (✓)

- ☐ Allergies to drugs
- ☐ Allergies to anesthetics
- ☐ Any heart ailments
- ☐ High blood pressure
- ☐ Neurological problems
- ☐ Radiation treatments
- ☐ Excessive bleeding from cut or extraction
- ☐ Anemia or blood problems
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ 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
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer or colitis
- ☐ Pregnancy
  If so, what month _____
- ☐ Venereal disease
- ☐ Other _____

Describe any current medical treatment including drugs taken, even though not listed above _____

INSURED'S NAME _____ INSURED'S SSN _____

INSURED'S DOB _____

PRIMARY INSURANCE COMPANY _____ GROUP # _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ INS. CO. PHONE # _____

SECONDARY INSURANCE COMPANY _____ GROUP # _____

INSURED'S NAME _____ INSURED'S SSN _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ INS. CO. PHONE # _____

INSURED'S DOB _____

ARE THERE ANY OTHER FAMILY MEMBERS IN OUR PRACTICE? _____

TREATMENT AUTHORIZATION AND ACKNOWLEDGEMENTCONSENT: As the undersigned, I hereby authorize Doctor to, after thorough explanation, take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a diagnosis of my dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated (after they are discussed with me) and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependent is mine irrespective of any dental insurance coverage I may have.

Signature of Patient, Parent orResponsible Party _____

Relationship to Patient _____

Date _____ Witness _____

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

_____ SIGNED (PATIENT, OR PARENT IF MINOR) _____ DATE

_____ SIGNED (INSURED PERSON) _____ DATE