

PATIENT'S HISTORY AND INFORMATION

(CONFIDENTIAL INFORMATION FOR OUR FILES)

(Please Print Clearly) Soc. Sec. No. _____ Date _____

Name _____ M F Birthdate _____

Res. Address _____ City _____ Zip _____ Res. Phone _____

Bus. Address _____ City _____ Zip _____ Bus. Phone _____

Employed by _____ Occupation _____ Spouse's Name _____

Referred By _____ Spouse's SSN _____

Spouse's Bus. Address _____ Bus. Phone _____

Employed By _____ Occupation _____ Spouse Date of Birth _____

Person Financially Responsible _____ Relationship _____

Res. Address _____ Res. Phone _____

Name of Group Dental Plan _____ Group No. _____

Emergency contact _____ Phone No. _____

_____ Dental history review.

PRACTITIONER USE ONLY!

Oral Cancer exam _____

DENTAL CONDITION

General Condition of Gingiva & Periodontium	
General Condition of Teeth	
Plaque	Calculus
Bleeding	Recession
TMJ Symptoms	
Other	

Prognosis of max. denture

Good Fair Poor

(Why) _____

Prognosis of mand. denture

Good Fair Poor

(Why) _____

Medical History

Patient Name: _____ Date of Birth: _____

Name and Address of Physician: _____

Date of Last Physical Exam: _____

Date of Last Dental Exam & X-Ray: _____

Medications

List all medications, including herbal remedies, you are taking and for what condition:

Medication	Condition	Medication	Condition
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Conditions

Please check any of the following conditions you currently have or have had at any time in the past. Please also include the date of diagnosis if known. **Please check none of the above if none apply.**

- | | |
|--------------------------------|--------------------------------|
| Heart Trouble _____ | High Blood Pressure _____ |
| Rheumatic Fever _____ | Heart Murmur _____ |
| Mitral Valve Prolapse _____ | Pacemaker _____ |
| Angina Pectoris _____ | Artificial Heart Valve _____ |
| Anemia _____ | Heart Surgery _____ |
| Glaucoma _____ | HIV _____ |
| Kidney Disease _____ | AIDS _____ |
| Liver Disease _____ | Arthritis _____ |
| Epilepsy or Seizures _____ | Asthma _____ |
| Cancer or Tumor _____ | Diabetes _____ |
| Chemotherapy _____ | Sinus Trouble _____ |
| Radiation Therapy _____ | Tuberculosis _____ |
| Joint Replacement _____ | Ulcers _____ |
| Psychiatric Treatment _____ | Fainting or Dizzy Spells _____ |
| Stroke _____ | Bruise Easily _____ |
| Ulcers _____ | Sickle Cell Disease _____ |
| Thyroid Problems _____ | Blood Transfusion _____ |
| Developmentally Disabled _____ | Hemophilia _____ |
| Hepatitis A, B, or C _____ | Cold Sores _____ |
- Any other condition not mentioned above: _____

None of the Above _____

Do you have dentures? Yes No

If so, how old are they? _____

Do you have partials or flippers? Yes No

If so, how old are they? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient signature _____ Date _____

Provider Signature _____ Date _____

Comments: _____

Provider Initial _____ Date _____

Comments: _____

Provider Initial _____ Date _____

Comments: _____

Provider Initial _____ Date _____

Comments: _____

History

- | | | |
|---|-------|-------|
| | yes | no |
| 1. Are you allergic to any medications or drugs? _____ | _____ | _____ |
| If so, please list: _____ | | |
| 2. Have you had any unusual reaction to "Novocaine" or any other local anesthetic? _____ | _____ | _____ |
| 3. Have you ever had problems with prolonged bleeding from a cut, injury or tooth extraction? _____ | _____ | _____ |
| 4. Have you ever used, or are you currently using any narcotic drugs? _____ | _____ | _____ |
| 5. Are you in a substance recovery program? _____ | _____ | _____ |
| 6. Do you smoke? If so, how much? _____ | _____ | _____ |
| 7. Do you drink alcoholic beverages on a regular basis? If so, how much? _____ | _____ | _____ |
| 8. Do you have an allergy or other reaction to any metal? _____ | _____ | _____ |
| 9. Do you have any disease, condition or problem not previously listed? If so, please explain _____ | _____ | _____ |

Women Only

- | | | |
|--|-------|-------|
| | yes | no |
| Are you taking birth control medications or any other hormone? _____ | _____ | _____ |
| Are you pregnant, nursing, or possibly pregnant? _____ | _____ | _____ |