PATIENT INFORMATION AND HEALTH HISTORY

INITIAL EXAM

DATE _____

PATIENT'S NAME _____ DATE OF BIRTH _____

SINGLE (MARRIED) DIVORCED SEPERATED WIDOWED

PATIENT'S ADDRESS _____

_____ PATIENT'S SS# _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ CELL PHONE _____ HOME PHONE _____

RESIDENCE ADDRESS _____ BUS. PHONE _____

EMPLOYED BY _____

BUSINESS ADDRESS _____ INS. CARRIER'S SS # _____

DENTAL INSURANCE PLAN (IF ANY) _____ REFERRED BY _____

PATIENT'S NAME _____

DENTAL HISTORY

CHIEF ORAL COMPLAINT _____

DATE OF LAST DENTAL EXAM _____ ANY PREVIOUS UNFAVORABLE DENTAL EXPERIENCE, ☐YES ☐NO EXPLAIN _____

DO YOU HAVE OR USE OR USE ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Traumatic injury to mouth or teeth
- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums, How long _____
- ☐ Food impaction
- ☐ Clenching or grinding of teeth
- ☐ 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**
- ☐ **Inter dental stimulators**
- ☐ **Water jet device**
- ☐ **Disclosing tablets or solution**
- ☐ **Fluoride supplements**
- ☐ **HIV**

MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST **PHYSICAL** EXAM _____

DO YOU HAVE OR USE OR USE ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Allergy to Penicillin
- ☐ Allergies to other drugs
- ☐ Allergies to anesthetics
- ☐ Any heart ailments
- ☐ Radiation Treatments
- ☐ Excessive bleeding from cut or extraction
- ☐ Anemia or blood problems
- ☐ Asthma
- ☐ Hay fever or allergies in general
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Liver problems or hepatitis
- ☐ Malignancies or Leukemia
- ☐ Psychiatric care/emotional problems
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Physical or mental handicap
- ☐ Thyroid Disorders
- ☐ Eye disorders
- ☐ Tonsilitis
- ☐ Ulcer or colitis
- ☐ Extreme nervousness or apprehension
- ☐ Other _____
- ☐ HIV

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

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for the patient.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish the persons responsible to know that all professional services rendered are charged directly to them and that they are personally responsible for payment of fees. We will prepare necessary forms or reports to help the persons responsible obtain benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

SIGNATURE _____ DATE _____

PARENT OR GUARDIAN IF PATIENT IS A MINOR