

CONFIDENTIAL PATIENT INFORMATION

We appreciate referrals, whom may we thank for referring you _____

Date: _____

Dr. Mr. Mrs.

Ms. Miss Mst.

NAME: _____

How would you prefer to be addressed? FIRST _____ LAST _____ INITIAL _____

Please list other family members attending this office.

ADDRESS: _____
STREET UNIT # CITY PROV. POSTAL CODE

HOME PHONE _____ BUSINESS _____ OTHER _____

EMAIL _____ FAX _____

DATE OF BIRTH _____ SEX _____ OCCUPATION _____
DAY/MONTH/YEAR

EMPLOYED BY _____

IN CASE OF EMERGENCY _____

NAME & DATE OF BIRTH OF INSURED MEMBER _____

PERSON RESPONSIBLE FOR ACCOUNT: SAME AS ABOVE OR _____

NAME

ADDRESS

MEDICAL HISTORY

1. DATE OF LAST MEDICAL EXAMINATION _____

2. NAME OF PHYSICIAN _____ PHONE _____

3. IS YOUR PHYSICIAN TREATING YOU NOW? IF YES, PLEASE SPECIFY YES NO

4. ARE YOU ON MEDICATION? IF YES PLEASE LIST MEDICATION YES NO

5. DO YOU HAVE DRUG ALLERGIES? e.g., Penicillin YES NO

IF YES PLEASE SPECIFY _____

6. HAVE YOU EVER HAD OR BEEN TREATED FOR?

- Respiratory Disease Yes No
- Hepatitis Yes No
- Tuberculosis Yes No
- Low Blood Pressure Yes No
- Stroke Yes No
- Scarlet Fever Yes No
- Sinus Yes No
- Heart Disease Yes No
- Nervous Problems Yes No
- Epilepsy Yes No

- High Blood Pressure Yes No
- Herpes Yes No
- Rheumatic Fever Yes No
- Anemia Yes No
- Liver Problems Yes No
- Abnormal Bleeding Yes No
- Ulcer Yes No
- Shortness of Breath Yes No
- Arthritis Yes No
- Dizzy Spells Yes No

please complete other side

continued from other side

- | | | | | | |
|--------------------------------|------------------------------|-----------------------------|------------------------|------------------------------|-----------------------------|
| Thyroid Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Blood Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest Pains | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Aids or HIV Positive | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Drug Dependence | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Psychiatric Problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | General Allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Disease of Eyes, Ears, | | |
| Latex Allergy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Nose or Throat. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hip, knee or joint replacement | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

7. ARE YOU PREGNANT? Yes No MONTH _____

8. IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR HEALTH?
PLEASE SPECIFY (INCLUDE SURGERY) _____

DENTAL HISTORY

1. Are you having discomfort at this time? Yes No Please Specify _____

2. Have you been under regular care by a dentist? Yes No

3. Previous dentist? _____ Last visit? _____

4. What was done at this time? _____

5. Do your gums feel tender or swollen? Yes No

6. Are you aware of any lump or swelling in your mouth? Yes No

7. Do you wear a full or partial denture Yes No

8. Do you have dental implants? Yes No

9. Have you ever had a problem with local or general anesthetic Yes No

10. Are you tense during dental visits? Yes No

11. Would you be interested in improving the appearance of your teeth? Yes No

12. Describe in your own words what you would like done with your teeth. _____

- | | | | | | |
|-------------------------|--|-------------------------|--|---------------------|--|
| loose teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No | bleeding gums | <input type="checkbox"/> Yes <input type="checkbox"/> No | sore gums | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| sensitive teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No | bad breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | popping or clicking | |
| earache | <input type="checkbox"/> Yes <input type="checkbox"/> No | unexplained nose bleed | <input type="checkbox"/> Yes <input type="checkbox"/> No | in the jaws joints | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| spaced or crooked teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No | unsatisfactory dentures | <input type="checkbox"/> Yes <input type="checkbox"/> No | missing teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | gagging | <input type="checkbox"/> Yes <input type="checkbox"/> No |

CONSENT:

I, _____ name _____, consent to the performing of the dental procedures agreed to be necessary or advisable for myself or _____ / _____ Patients Name _____, and furthermore, I will assume responsibility for fees associated with those procedures. relationship _____

Signatures _____ Date _____

I authorize release, to my insuring company/plan administrator, the information contained in claims submitted electronically.

Signature of Patient

Parent /Guardian

Witness

Date