Medical Information

Patient Name:_____

Birth Date _____

Home Ph (___)_____ Work Ph (___)_____ Cell Ph (___)_____

Address_____

City_____ Postal Code _____

Email _____

Name of Physician _____ Phone # (___)_____

Emergency Contact _____ **Phone #** (___)_____

*How did you find out about us?*_____

Insurance Information

Name of Policy Holder _____ Birth date _____

Policy Holder's Employer ____ _____

Name of Insurance Company _____ Group/Policy # _____ ID# _____

Do you have additional Insurance? _Yes _ No If yes, please complete the following:
Name of Policy Holder _____ Birth date _____
Policy Holder's Employer _____
Name of Insurance Company _____ Group/Policy # _____ ID# _____

Patient Dental History

Name of previous Dentist _____ Date of last exam _____

1. Do your gums bleed while brushing or flossing? __ Yes __ No
2. Are your teeth sensitive to hot or cold temperatures? __ Yes __ No
3. Are your teeth sensitive to sweet or sour liquids/foods? __ Yes __ No
4. Do you feel pain in any of your teeth? __ Yes __ No
5. Do you have any sores or lumps in or near your mouth? __ Yes __ No
6. Have you had any head or neck injuries? __ Yes __ No
7. Have you experienced any of the following problems in your jaw? __ Yes __ No
   - __ Clicking
   - __ Difficulty in opening or closing
   - __ Pain (joint, ear, side of face)
   - __ Difficulty chewing
8. Do you have frequent headaches? __ Yes __ No
9. Do you clench or grind your teeth? __ Yes __ No
10. Do you ever wake from sleep with shortness of breath? __ Yes __ No
11. Have you had any difficult extractions in the past? __ Yes __ No
12. Have you ever had any prolonged bleeding following extractions? __ Yes __ No
13. Have you had any orthodontic treatment? __ Yes __ No
14. Do you wear dentures or partials? __ Yes __ No
    If yes, date of placement _____
15. Have you ever received oral hygiene instructions for the care of your teeth and gums? __ Yes __ No
16. Do you feel nervous about having dental treatment? __ Yes __ No
    If yes, why? _____
17. Do you like your smile? __ Yes __ No

Patient Medical History

1. Are you under medical treatment now? __ Yes __ No
2. Have you been hospitalized within the last 5 years? __ Yes __ No
   If yes, please explain _____
3. Are you taking any medications including non-prescription medicine? __ Yes __ No
   If yes, what medications are you taking? _____
   _____
   _____
4. Have you lost or gained more than 10lbs in the past year? __ Yes __ No
5. When you walk up stairs, do you have to stop because of chest pain, shortness of breath? __ Yes __ No
6. Do your ankles swell during the day? __ Yes __ No
7. Are you on a special diet? __ Yes __ No
8. Do you have or have you had any of the following? (please circle)

Sinus trouble	Diabetes Type I or II	Stroke
Arthritis	Radiation therapy	Heart Pacemaker
Cortisone Medication	Chemotherapy	Artificial Joint Replacement
Glaucoma	Leukemia	Rheumatic Fever
Sickle Cell Disease	Cancer	Ulcers
Anemia	Epilepsy or Seizures	Stomach Troubles/GERD
Hemophilia	Fainting or Dizzy spells	Kidney Trouble
Bruise easily	Nervousness	Thyroid Disease
Hepatitis A (Infectious)	Psychiatric Treatment	Emphysema/COPD
Hepatitis B (Serum)	Chest pains (Angina Pectoris)	Tuberculosis
Hepatitis C	Easily winded	Asthma
Liver Disease	Swollen ankles	Scarlet Fever
Jaundice	Heart attack (Myocardial Infarction)	Cold Sores
Blood transfusion	Artificial Heart Valve	STD/Venereal Disease
Drug addiction	Mitral Valve Prolapse	Hay Fever
AIDS-HIV Positive	Congenital Heart Lesions	Other: _____
High Blood Pressure	Heart failure/Disease	
Low Blood Pressure	Heart surgery	

9. Are you allergic to or have you had a reaction to any of the following? (please circle)

Local Anesthesia (i.e. Novocain)	Sedatives	Any Metals (i.e. Nickel, Mercury, etc.)
Penicillin	Iodine	Latex Rubber
Sulfa Drugs	Aspirin	Other: _____
Barbiturates	Codeine	

10. **Women only:** Are you Pregnant or Nursing? __ Yes __ No

Authorization and Release

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. I authorize the dentist to release any information including the diagnosis and the third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all records of any treatment or examination rendered to me or my child during the period of such dental care to services rendered on my behalf or my dependents. I authorize the dentist to submit my insurance claims electronically on my behalf.

X _____ Date _____

Signature of patient (or guardian if minor)