PATIENT INFORMATION AND HEALTH HISTORY

Name: _____ Date of Birth: _____ Age _____

SSN# _____ Home Phone: _____ Cell Phone: _____

Mailing Address: _____ Email : _____

Employed By : _____ Work Phone: _____

Name of Spouse: _____ Spouse's DOB: _____Spouse Employed By: _____

Dental Insurance: Yes / No (circle one) Subscriber of Ins.: _____

Insurance Co Name & Address for Claims: _____

Subscriber ID/Policy # _____ Group # _____

Who Referred You? _____ Your Physician's Name: _____

Date of Last Dental Exam/Cleaning: _____ Last Medical Check-Up: _____

PATIENT DENTAL HISTORY:

Are you having discomfort at this time? If so, please explain: _____
What is your main concern/problem with your teeth? _____
Have you had a bad dental experience? _____
Describe what you do each day to keep your mouth, gums, and teeth healthy? _____
Please check any of the following you are experiencing: _____ bleeding gums _____ bad breath
____ bad taste in your mouth ____ sore or tender gums _____ pus between teeth & gums
____ permanent teeth loose or separating _____ change in your bite ___ popping/clicking in jaw
____ frequent/severe headaches _____ swelling or lump in mouth

PATIENT MEDICAL HISTORY – Check If You Have or Have Had Any of The Following

_____ AIDS	_____ Diabetes	_____ Radiation	_____ Chemotherapy
_____Allergies	_____ Excessive Bleeding		_____ Rheumatic Fever
_____ Anemia	_____ Heart Problems		_____ Scarlet Fever
_____ Arthritis	_____ Heart Murmur or MVP		_____ Heart Attack
_____ Artificial Prosthesis		_____ Hepatitis	_____ Sinus Problems
_____ Asthma	_____ Herpes	_____ Tonsillitis	_____ Hi/Lo Blood Pressure
_____ Circulatory Problems		_____ Malignancies	_____ Tuberculosis
_____ Nerve Problems		_____ Venereal Disease	_____ Stroke

_____ Surgery – if yes what kind and when? _____

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING: _____

PLEASE LIST ANY ALLERGIES YOU HAVE:

Signature : _____ Date: _____