

**Confidential Dental & Medical History**

Please PRINT & Complete ALL Information. By Law, all information must be kept strictly confidential.

**PATIENT INFORMATION:**

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex:  M  F Marital Status:  M  S  W  D  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ H-Phone \_\_\_\_\_  
Soc.Sec.No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License No. \_\_\_\_\_ W-Phone \_\_\_\_\_ C-Phone \_\_\_\_\_  
Credit Card I.D. \_\_\_\_\_ Expire Date \_\_\_\_\_ - \_\_\_\_\_ Shall we charge your portion to this card?  YES  NO.

**ARE YOU COVERED BY DENTAL INSURANCE?**  YES  NO **WHOSE?:**  My Own;  Spouse;  Mother;  Father;  Guardian.

Previous Dentist \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Last Seen \_\_\_\_\_ months ago.  
Why did you leave her/him? (CONFIDENTIAL): \_\_\_\_\_

Physician's Name: \_\_\_\_\_ May we contact her/him for consultation, if necessary?  YES  NO.  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone \_\_\_\_\_

Other Physicians seen is last 5 years \_\_\_\_\_

**EMERGENCY CONTACT NAME:** \_\_\_\_\_ H Phone \_\_\_\_\_ W Phone \_\_\_\_\_

**Who is Responsible for this Account?**

Name \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ H-Phone \_\_\_\_\_

**DENTAL INSURANCE INFORMATION;**

Patient or Parent's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc.Sec.No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Employer \_\_\_\_\_ Dental Insur. Co. \_\_\_\_\_ Insur Contract No. \_\_\_\_\_ Group No. \_\_\_\_\_  
Patient or Parent's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc.Sec.No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Employer \_\_\_\_\_ Dental Insur. Co. \_\_\_\_\_ Insur Contract No. \_\_\_\_\_ Group No. \_\_\_\_\_

**Who Referred You to Our Office** (SO WE MAY THANK THEM): \_\_\_\_\_

**DENTAL HISTORY:** (Please Answer All Questions By Checking  YES or  NO )

Date of Last Dental Visit: \_\_\_\_\_ What Was Done: \_\_\_\_\_

Reason for TODAY's Visit (BE SPECIFIC): \_\_\_\_\_

**HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Check Yes or No):**

Yes No <input type="checkbox"/> <input type="checkbox"/> Dentures or Partial Dentures	Yes No <input type="checkbox"/> <input type="checkbox"/> Loose Teeth	Yes No <input type="checkbox"/> <input type="checkbox"/> Complications After Extraction
<input type="checkbox"/> <input type="checkbox"/> Clenching or Grinding Teeth	<input type="checkbox"/> <input type="checkbox"/> Gums Bleed Often	<input type="checkbox"/> <input type="checkbox"/> Gag Easily
<input type="checkbox"/> <input type="checkbox"/> Clicking or Popping	<input type="checkbox"/> <input type="checkbox"/> Food Packing Between Teeth	<input type="checkbox"/> <input type="checkbox"/> Treated for Gum Disease
<input type="checkbox"/> <input type="checkbox"/> Lip or Mouth Blisters or Ulcers	<input type="checkbox"/> <input type="checkbox"/> Tired Feeling Jaws	<input type="checkbox"/> <input type="checkbox"/> Orthodontics, _____ Yrs ago
<input type="checkbox"/> <input type="checkbox"/> Lump or Swelling in Mouth	<input type="checkbox"/> <input type="checkbox"/> Many Cavities At One Time	<input type="checkbox"/> <input type="checkbox"/> Breathing Through Mouth, Snoring
<input type="checkbox"/> <input type="checkbox"/> Bad Breath or Unpleasant Taste	<input type="checkbox"/> <input type="checkbox"/> Loose or Broken Teeth or Fillings	<input type="checkbox"/> <input type="checkbox"/> Other: _____

How Often Do You Brush Your Teeth? \_\_\_\_\_ times a day. How often do you floss your teeth? \_\_\_\_\_ times a week.

Yes No <input type="checkbox"/> <input type="checkbox"/> Do You Avoid Brushing Any Area of Your Mouth?	Do Your Teeth Ache When They Yes No <input type="checkbox"/> <input type="checkbox"/> Contact Any of These?:	Do You Use Any of the Following?: Yes No
<input type="checkbox"/> <input type="checkbox"/> Do You Know What Preventive Dental Care Is?	<input type="checkbox"/> <input type="checkbox"/> HOT Food or Drinks	<input type="checkbox"/> <input type="checkbox"/> Toothpicks of Any Kind
<input type="checkbox"/> <input type="checkbox"/> Do You Bite Lips, Cheeks or Fingernails?	<input type="checkbox"/> <input type="checkbox"/> COLD Food or Drinks	<input type="checkbox"/> <input type="checkbox"/> Water – Jet Device
<input type="checkbox"/> <input type="checkbox"/> Do You Avoid Chewing Anywhere?	<input type="checkbox"/> <input type="checkbox"/> SWEET Food or Drinks	<input type="checkbox"/> <input type="checkbox"/> Electric Toothbrush
<input type="checkbox"/> <input type="checkbox"/> Do You Like the Appearance of Your Teeth?	<input type="checkbox"/> <input type="checkbox"/> SOUR Food or Drinks	<input type="checkbox"/> <input type="checkbox"/> Fluoride Supplements
<input type="checkbox"/> <input type="checkbox"/> Any Serious Problems with Prior Dental Treatment?		

Any Comments?: \_\_\_\_\_

**Extra Dental History for Children:**

Yes No <input type="checkbox"/> <input type="checkbox"/> Is This Your Child's First Visit To The Dentist?	Yes No <input type="checkbox"/> <input type="checkbox"/> Does Your Child Take Fluoride Supplements?
<input type="checkbox"/> <input type="checkbox"/> Does Your Child Brush His/Her Own Teeth?	<input type="checkbox"/> <input type="checkbox"/> Does Your Child Floss His/Her Own Teeth?
<input type="checkbox"/> <input type="checkbox"/> Has Your Child Had Topical Fluoride Treatment Before?	<input type="checkbox"/> <input type="checkbox"/> Any Difficulty Accepting Fluoride Treatment?
<input type="checkbox"/> <input type="checkbox"/> Has Your Child Had Difficulty Accepting Dental Treatment Before?	

**PLEASE TURN OVER TO FINISH**

**MEDICAL HISTORY:** (Do You Have, Or Have You Ever Had Any Of The Following)

- Yes No  
  A Change In Your Health This Past Year?  
  Are You Now Receiving ANY Medical Treatment?  
  Are You Taking Any Medications Now?

Explain: \_\_\_\_\_  
\_\_\_\_\_

- Have You Ever Been Hospitalized Or Seriously Ill?  
 Explain: \_\_\_\_\_  
  An ALLERGY To ANY Medicine?

Explain: \_\_\_\_\_

- Any Abnormal Or Prolonged Bleeding?  
  Do You  Bleed Or  Bruise Easily?  
  Frequent Or Severe Headaches? How Often? \_\_\_\_\_  
  Do You Urinate More Than 6 Times/Day Or 2 Times/Night?  
  Any Relative Have Diabetes? Who?: \_\_\_\_\_  
  Have You Or A Relative Had A Tumor Or Cancer?

Explain: \_\_\_\_\_  
\_\_\_\_\_

- Yes No  
  Do You Have A Pacemaker?  
  Do You Smoke Or Use Any Form Of Tobacco?  
 Cigarettes  Cigars  Pipe  Smokeless Tobacco  
 How Much Do You Use Daily? \_\_\_\_\_

- Do You Drink Alcoholic Beverages?  
 How Much? \_\_\_\_\_ How Often? \_\_\_\_\_

- Have You Ever Had An Injury To Your Head, Face Or Teeth?

**Women Only:**

- Are You Pregnant? How Many Months? \_\_\_\_\_  
  Are You Taking Birth Control Pills?  
  Have You Had Excessive Menstrual Bleeding?  
  Have You Reached Menopause?

**For All Patients:**

- Do You Have Any Other Medical Problems? Explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- Have You Ever Used Or Abused Cocaine, Crack, Heroin, LSD, Marijuana Or Any Other Prescribed Or Non-Prescribed Drug?

**Please Mark  Or  All Of The Conditions You Have Ever Had:**

- |   |   |   |   |
|---|---|---|---|
| Yes<br><input type="checkbox"/> Rheumatic Fever       | Yes<br><input type="checkbox"/> Heart Murmur              | Yes<br><input type="checkbox"/> Hepatitis / Jaundice    | Yes<br><input type="checkbox"/> Diabetes              |
| <input type="checkbox"/> Prosthetic Heart Valve       | <input type="checkbox"/> Born with Heart Disease          | <input type="checkbox"/> Heart Infection (Endocarditis) | <input type="checkbox"/> Joint Replacement or Surgery |
| <input type="checkbox"/> High / Low Blood Pressure    | <input type="checkbox"/> Asthma                           | <input type="checkbox"/> Epilepsy / Convulsions         | <input type="checkbox"/> TB / Tuberculosis            |
| <input type="checkbox"/> Heart Transplant             | <input type="checkbox"/> Allergy, Hay Fever, Sinus        | <input type="checkbox"/> Fainting                       | <input type="checkbox"/> Breathing Problems           |
| <input type="checkbox"/> Kidney or Liver Disease      | <input type="checkbox"/> Thyroid Disease                  | <input type="checkbox"/> Glaucoma                       | <input type="checkbox"/> Psychiatric Treatment        |
| <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Rheumatoid Arthritis             | <input type="checkbox"/> Chronic Cough                  | <input type="checkbox"/> Chest Pains                  |
| <input type="checkbox"/> Herpes (Cold Sores)          | <input type="checkbox"/> Anemia                           | <input type="checkbox"/> Tonsillitis                    | <input type="checkbox"/> Neurological Problems        |
| <input type="checkbox"/> Exposure to AIDs / HIV       | <input type="checkbox"/> Exposure to I.V. Drugs           | <input type="checkbox"/> Chicken Pox                    | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Ulcers                       | <input type="checkbox"/> Any Other Medical Problem: _____ |   |   |

Any Explanation: \_\_\_\_\_

**Please Mark  Or  All The Medicines You Are Taking Or Have Taken In Past 5 Years:**

- |  |  |   |  |
|--|--|---|--|
| Yes<br><input type="checkbox"/> Penicillin / Amoxicillin | Yes<br><input type="checkbox"/> Blood Thinners | Yes<br><input type="checkbox"/> Aspirin w/ or w/o Codeine | Yes<br><input type="checkbox"/> Insulin  |
| <input type="checkbox"/> Other Antibiotics               | <input type="checkbox"/> Blood Pressure        | <input type="checkbox"/> Tylenol w/ or w/o Codeine        | <input type="checkbox"/> Anti-Convulsant |
| <input type="checkbox"/> Thyroid Supplements             | <input type="checkbox"/> Heart Medication      | <input type="checkbox"/> Other Pain Medications           | <input type="checkbox"/> Tranquilizers   |
| <input type="checkbox"/> Cortisone / Steroids            | <input type="checkbox"/> Nitroglycerine        |   |  |
- Other Medication: \_\_\_\_\_

**Informed Consent for Treatment:** All above information is complete and correct, to my best knowledge. I hereby authorize release of any information for an insurance claim or a medical or dental consultation. **I hereby give my informed consent for my (or my child's) treatment. I fully understand that I am responsible for the payment of all charges for dental treatment,** even though I may have insurance that may cover a part of the charges. I also know, ahead of any treatment, that late payments & the account balance are subject to 1.5% monthly late fee and I am responsible for all costs for collection if my account goes to a collection agency.

\_\_\_\_\_  
Signature of Patient (Parent or Guardian)

\_\_\_\_\_  
Today's Date

Medical Dr.'s or Hygienist Notes: \_\_\_\_\_  
Update \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_