

Patient Information & Health History

DATE: _____
PATIENT NAME: _____ DOB: _____
PERSON RESPONSIBLE FOR ACCOUNT: _____
ADDRESS: _____ APT#: _____ PHONE #: _____
CITY: _____ STATE: _____ ZIP CODE: _____
EMPLOYED BY: _____
BUSINESS ADDRESS: _____ PHONE #: _____
CITY: _____ STATE: _____ ZIP CODE: _____
DENTAL INSURANCE PLAN _____
EMAIL: _____

Dental History

CHIEF ORAL COMPLAINT: _____
DATE OF LAST DENTAL EXAM: _____ PREVIOUS MAJOR DENTAL WORK? IF YES, WHEN? _____

PLEASE INDICATE WITH AN (X) IF YOU HAVE OR USE ANY OF THE FOLLOWING:

- | | | |
|--|---|---|
| <input type="radio"/> Teeth Sensitive | <input type="radio"/> Bad Breath | <input type="radio"/> Smoking of any kind |
| <input type="radio"/> Bleeding Gums | <input type="radio"/> Unpleasant taste | Texture of Toothbrush _____ |
| <input type="radio"/> Food impaction | <input type="radio"/> Unfavorable dental experience | Frequency of brushing _____ |
| <input type="radio"/> Clenching or grinding | <input type="radio"/> Complications from extraction | <input type="radio"/> Do you use dental floss |
| <input type="radio"/> Burning of tongue | <input type="radio"/> Periodontal treatment | <input type="radio"/> Inter dental stimulators |
| <input type="radio"/> Swelling or lumps in mouth | <input type="radio"/> Orthodontic treatment | <input type="radio"/> Water jet device |
| <input type="radio"/> Pain in ear | <input type="radio"/> Mouth Breathing | <input type="radio"/> Disclosing tablets or solutions |
| <input type="radio"/> Unusual sounds in ear | <input type="radio"/> Oral habits (fingernail biting... etc.) | <input type="radio"/> Fluoride supplements |

Medical History

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

PLEASE INDICATE WITH AN (X) IF YOU HAVE OR USE ANY OF THE FOLLOWING:

- | | | |
|--|---|---|
| <input type="radio"/> Allergies to drugs | <input type="radio"/> Arthritis | <input type="radio"/> Psychiatric care/emotional |
| <input type="radio"/> Allergies to anesthetics | <input type="radio"/> Sinus problems | <input type="radio"/> Rheumatic fever |
| <input type="radio"/> Any hearth ailments | <input type="radio"/> Asthma | <input type="radio"/> Immune System Disorders
(Aids, HIV, ARC) |
| <input type="radio"/> High blood pressure | <input type="radio"/> Hay fever or allergies in general | <input type="radio"/> Stroke |
| <input type="radio"/> Neurological problems | <input type="radio"/> Diabetes | <input type="radio"/> Eye disorders |
| <input type="radio"/> Radiation treatments | <input type="radio"/> Kidney problems | <input type="radio"/> Tonsillitis |
| <input type="radio"/> Excessive bleeding | <input type="radio"/> Liver problems or Hepatitis | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Anemia of blood problems | <input type="radio"/> Malignancies | |

HOW DID YOU HEAR ABOUT US?

- | | | |
|-------------------------------------|---------------------------------------|-------------------------------------|
| <input type="radio"/> Yelp | <input type="radio"/> Just Walking By | <input type="radio"/> Dentist _____ |
| <input type="radio"/> Google | <input type="radio"/> Facebook | <input type="radio"/> Patient _____ |
| <input type="radio"/> Friend/Family | <input type="radio"/> ZocDoc | <input type="radio"/> Other _____ |

PATIENT SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY

Review Medical _____

Review Benefits & Risks _____