

PATIENT INFORMATION

CONFIDENTIAL

PATIENT # _____

DATE _____

PLEASE FILL IN ALL APPLICABLE FIELDS

NAME _____ BIRTH DATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE _____ CITY _____ STATE _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

SOCIAL SECURITY NUMBER _____

EMPLOYER _____ WORK PHONE _____

ADDRESS _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTH DATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION/LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO

IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTH DATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION/LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

X SIGNATURE OF PATIENT OR PARENT, IF MINOR

PATIENT NAME _____ TODAY'S DATE _____
 HOME ADDRESS _____ DATE OF BIRTH _____
 CITY _____ STATE _____ ZIP _____ HOME PHONE _____
 BUSINESS ADDRESS _____ BUSINESS PHONE _____
 CITY _____ STATE _____ ZIP _____ SOC. SEC. NO. _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

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| <p>1. ARE YOU UNDER MEDICAL TREATMENT NOW <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION FOR SERIOUS ILLNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? IF YES, WHAT MEDICATION(S) ARE YOU TAKING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>4. DO YOU USE TOBACCO? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. ARE YOU WEARING CONTACT LENSES? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | <p>7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS? IF YES, PLEASE SPECIFY.</p> <p>8. WHEN WAS YOUR LAST COMPLETE PHYSICAL?</p> <p>9. WOMEN ONLY: YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT(?) <input type="checkbox"/> <input type="checkbox"/></p> <p>B) ARE YOU NURSING? <input type="checkbox"/> <input type="checkbox"/></p> <p>C) ARE YOU TAKING BIRTH CONTROL PILLS <input type="checkbox"/> <input type="checkbox"/></p> |
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10. PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

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| <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> HEART ATTACK <input type="checkbox"/> RHEUMATIC FEVER <input type="checkbox"/> SWOLLEN ANKLES <input type="checkbox"/> FAINTING/SEIZURES <input type="checkbox"/> ASTHMA <input type="checkbox"/> LOW BLOOD PRESSURE <input type="checkbox"/> EPILEPSY/CONVULSIONS <input type="checkbox"/> LEUKEMIA <input type="checkbox"/> DIABETES | <input type="checkbox"/> HEART DISEASE <input type="checkbox"/> CARDIAC PACE MAKER <input type="checkbox"/> HEART MURMUR <input type="checkbox"/> ANGINA <input type="checkbox"/> FREQUENTLY TIRED <input type="checkbox"/> ANEMIA <input type="checkbox"/> EMPHYSEMA <input type="checkbox"/> CANCER <input type="checkbox"/> ARTHRITIS <input type="checkbox"/> JOINT REPLACEMENT OR IMPLANT | <input type="checkbox"/> CHEST PAINS <input type="checkbox"/> EASILY WINDED <input type="checkbox"/> STROKE <input type="checkbox"/> HAY FEVER/ALLERGIES <input type="checkbox"/> TUBERCULOSIS <input type="checkbox"/> RADIATION THERAPY <input type="checkbox"/> GLAUCOMA <input type="checkbox"/> RECENT WEIGHT LOSS <input type="checkbox"/> LIVER DISEASE <input type="checkbox"/> HEART TROUBLE | <input type="checkbox"/> KIDNEY DISEASES <input type="checkbox"/> AIDS/HIV INFECTION <input type="checkbox"/> THYROID PROBLEM <input type="checkbox"/> HEPATITIS/JAUNDICE <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE <input type="checkbox"/> STOMACH TROUBLE/ULCERS <input type="checkbox"/> RESPIRATORY PROBLEMS <input type="checkbox"/> OTHER |
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COMMENTS

PATIENT DENTAL HISTORY

PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

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| <p>1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? <input type="checkbox"/></p> <p>2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOOD? <input type="checkbox"/></p> <p>3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUID/FOODS? <input type="checkbox"/></p> <p>4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? <input type="checkbox"/></p> <p>5. DO YOU HAVE ANY SORES OR LUMPS IN YOUR EAR OR MOUTH? <input type="checkbox"/></p> <p>6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? <input type="checkbox"/></p> <p>7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?</p> <p>A) CLICKING? <input type="checkbox"/></p> <p>B) PAIN (JOINT, EAR, SIDE OF FACE)? <input type="checkbox"/></p> <p>C) DIFFICULTY IN OPENING OR CLOSING)? <input type="checkbox"/></p> <p>D) DIFFICULTY IN CHEWING? <input type="checkbox"/></p> | <p>8. DO YOU HAVE FREQUENT HEADACHES? <input type="checkbox"/></p> <p>9. DO YOU CLENCH OR GRIND YOUR TEETH? <input type="checkbox"/></p> <p>10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? <input type="checkbox"/></p> <p>11. HAVE YOU EVER HAD ANY DIFFICULTY EXTRACTIONS IN THE PAST? <input type="checkbox"/></p> <p>12. HAVE YOU HAD ANY ORTHODONTIC WORK? <input type="checkbox"/></p> <p>13. HAVE YOU HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS? <input type="checkbox"/></p> <p>14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? <input type="checkbox"/></p> <p>15. HAVE YOU EVER HAD INSTRUCTION ON THE CARE OF YOUR GUMS? <input type="checkbox"/></p> |
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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.

X PATIENT, PARENT OR GUARDIAN _____ DATE _____