Dental History

Date of Last Dental Visit: _____ Reason for this visit: _____

- Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

Do you presently or have ever had any of the following:

- ☐ Clinching or grinding
- ☐ Pain in or around ear
- ☐ Difficulty opening/Closing
- ☐ Gum Surgery
- ☐ Bad dental experience
- ☐ Jaw pops or clicks
- ☐ Frequent headaches
- ☐ Bleeding gums
- ☐ Previous Periodontal Treatment
- ☐ Had immediate relative lose all their natural teeth

- Are your teeth sensitive to : ☐ Hot ☐ Cold ☐ Biting ☐ Sweets
- Are you happy with the appearance of your teeth? ☐ Yes ☐ No

Patient Health Information

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ _____

- How would describe your present health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Are you taking any medications (This includes over the counter drugs)? ☐ Yes ☐ No
  If yes, please explain:_____
- **Are you allergic to any medications?** ☐ Yes ☐ No If yes, what:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____
- How would you describe your sleep? Does snoring have a significant effect on the quality of your life?
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

Patient Information

Patient Name: _____ Date: _____
Last First MI

Address: _____
Street Apartment #

_____
City State Zip Code

Social Security #: _____ Licence # _____ Birth Date: _____

☐ Male ☐ Female Married ☐ Single ☐ Child ☐ Other

Phone (Home): _____ (Work): _____ (Other): _____

E-Mail Address: _____

Insured Party or Responsible Party on Account

Responsible or Insured's Name _____ Is insured a patient? ☐ Yes ☐ No

Responsible or Insured's Address: _____
Street City State Zip Code

Phone (home) _____ Work _____ Other _____

SS# _____ Birth Date: _____ __Male_____Female_____Married_____Single_____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Insurance Plan Name and Address: _____

_____

Insurance Phone # _____

Ins ID #: _____ Group #: _____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend, relative

Dental Office, Yellow Pages, Newspaper, Office Sign, Other _____

Name of person or office referring you to our practice: _____

Emergency Contact: _____ Phone _____

Permit For Treatment

This is to certify that I, undersigned, consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable, including the use of local anesthetics as indicated, and I will assume responsibility for fees associated with those procedures. The above information is accurate to the best of my knowledge.

_____

Patients, Parent or Guardian Signature Date