PATIENT INFORMATION

ACCT. # ____________________

Note: The information on this form is necessary for our records. It is considered strictly confidential. Please complete all parts.

NAME ____________________ (LAST) ____________________ (FIRST) ____________________ (MIDDLE) AGE ______

ADDRESS ____________________ (STREET) ____________________ (CITY) ______ (STATE) ______ (ZIP CODE)

PHONE ______________ (RESIDENCE) ______________ (BUSINESS) CELL PHONE ______________ EMAIL ______________

DRIVER'S LICENSE # ____________________ STATE __________

SOC. SEC. NO. ____________________ BIRTH DATE __________

PHYSICIAN ____________________ PHONE ______________ REFERRED BY ______________

OCCUPATION ____________________ EMPLOYER ____________________

MEDICAL HISTORY

General health (please check): ☐ Excellent ☐ Good ☐ Fair ☐ Poor Last complete physical? __________

Findings? ____________________

Are you taking any medication now? ☐ Yes ☐ No
If yes, medication name/purpose: ____________________

____

Have you ever been treated for:

Heart disease	☐ Yes	☐ No	Heart murmur	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No
Abnormal blood pressure	☐ Yes	☐ No	Asthma or hay fever	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No	Sinus trouble	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Cough	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Congenital heart lesions	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
VD (Syphilis, Gonorrhea)	☐ Yes	☐ No	Serious accident	☐ Yes	☐ No
Herpes	☐ Yes	☐ No	AIDS	☐ Yes	☐ No

Have you ever been treated (other than diagnostic) with x-ray? ☐ Yes ☐ No

Are you allergic to: ☐ Penicillin ☐ Codeine ☐ Local injected anesthetics

☐ Other allergies to medications ____________________

Are you subject to prolonged bleeding? ☐ Yes ☐ No Are you subject to fainting spells? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No How long? __________

COMMENTS: ____________________

DENTAL HISTORY

Date of last dental visit ______________ Phone ______________

Are you dissatisfied with the appearance of your teeth?	☐ Yes	☐ No
Have you had orthodontic treatment?	☐ Yes	☐ No
Do you clench or grind your teeth during the day or night?	☐ Yes	☐ No
Have you ever had pain in your jaw joint or your face (in and about your ears)?	☐ Yes	☐ No
Do you have an unpleasant odor, or taste, in your mouth?	☐ Yes	☐ No
Do your gums bleed when brushing?	☐ Yes	☐ No
Have you had gum disease or pyorrhea?	☐ Yes	☐ No

Is your mouth or teeth sensitive to: Pressure? ☐ Yes ☐ No Cold? ☐ Yes ☐ No Hot? ☐ Yes ☐ No

Does food catch between your teeth? ☐ Yes ☐ No

Please add anything you feel is important for the doctor to know ____________________

____

____

Indicate any disease, condition, or problem not listed above that you think we should know about ______________

____

May we request/report information from or to a credit rating institution, i.e: TRW ☐ Yes ☐ No

REMARKS: ____________________

____

____

EMERGENCY PERSON ____________________ EMERGENCY NO. ______________

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.

Patient's (Parent's) Signature ____________________ Date __________

Interviewer's Signature ____________________