Confidential Patient History Form

Welcome!

Thank you for selecting our dental practice. We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us. We will be happy to help.

All About You

Name: ◻ Male ◻ Female

Last First Middle Preferred Name

Date of Birth:____________________ Age:_______ SSN:_________________________ Driver License #_________________

Home Address:____City/State:____________________________Zip:___________

Home #:___________________________ Cell #:_______________________________ Work #:___________________________________

E-Mail Address: __________________________________ Whom may we thank for referring you?________________________________

Marital Status: ◻ Single ◻ Married ◻ Life Partner ◻ Divorced ◻ Separated ◻ Widowed

Are you a student, full time? ◻ Yes ◻ No School Attending:____

Employer:__________________________________ Occupation:________________________ Human Resource Contact:________________

Address:____City/State:___________________________Zip:___________

Nearest relative not living with you:________________________________ Phone Number:_________________ Relationship:____________

Emergency Contact:____________________________ Relationship_______________________ Phone Number:____________________

Reason for changing dentist:____

Purpose of today's appointment:____ Is this an emergency?:_________________________

Physician and Dentist Information

Name of Physician:___________________________________ Phone #:__________________________ Fax_______________________

Business Address:______________________________________ City ___________________State _______ Zip Code __________________

Previous Dentist:____________________________________ Phone#:___________________________ Fax:______________________

Business Address:______________________________________ City___________________ State________ Zip Code: ________________

Financial Information and Responsible Party

Responsible Party/Insurance Policy Holder

Person responsible for this account:____ Date of Birth:_______________

Address:____

Home #:____________________ Cell # ____________________ Work #:___________________ E-mail ___________________________

Dental Insurance Information

Primary Dental Insurance Carrier: __________________________ Group/Policy#_________________Ins.Phone # ____________________

Policy Holder's Name:____________________________ Date of Bith:__________ SS# _________________ Phone #__________________

Secondary Dental Insurance Carrier :________________________Group/Policy#__________________ Ins. Phone# ___________________

Policy Holder's Name ____________________________ Date of Birth:_________ SS# _________________ Phone # __________________

Medical History

Is your current physical health: ◻ Poor ◻ Fair ◻ Good ◻ Great

Are you currently under the care of a physician? ◻ Yes ◻ No

If Yes, why?____

Date of last physical:_________________ Have you ever had or have a serious illness or been hospitalized? ◻ Yes ◻ No

If Yes, please explain: ____

Are you taking any prescriptions or over the counter drugs? ◻ Yes ◻ No

If yes, what are they and their dosage?____

Have you ever been pre-medicated for dental procedures? ◻ Yes ◻ No

Have you ever taken the drugs Phen Phen, Redux, or any diet drugs? If Yes, what?_______________________ ◻ Yes ◻ No

Are you allergic to any of the following?

Aspirin__ Latex ___ Codeine ___ Penicillin ___ Dental Anesthetics ___ Iodine ___ Tetracycline ___ Erythromycin ___ Sulfa Drugs ___ Jewelry/Metals___ Barbiturates___ Sedatives ___ Other _________________

Women Only

Are you pregnant or nursing? ◻ Yes ◻ No

Do you have any problems associated with your menstrual cycle? ◻ Yes ◻ No

Do you take any birth control medications or hormones? ◻ Yes ◻ No

Have you ever had any of the following disease or medical problems? (Please check all that apply)

- ☐ AIDS/HIV
- ☐ Allergies/Hives/Hay Fever
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Artificial Prosthesis/Joint Replacement
- ☐ Arthritis/Rheumatism
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer Type:__________________
- ☐ Cerebral Palsy
- ☐ Chemotherapy
- ☐ Congenital Heart Defect/Lesions
- ☐ Cortisone
- ☐ Diabetes Type:________________
- ☐ Difficulty Breathing/Respiratory
- ☐ Disease/OPD
- ☐ Difficulty Swallowing
- ☐ Drug/Alcohol Abuse or Addiction
- ☐ Eating Disorders
- ☐ Emphysema
- ☐ Epilepsy/Seizures/Fainting Spells
- ☐ Fever Blisters/Herpes/Cold Sores
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Hemophilia/Abnormal Bleeding/Blood Disease
- ☐ High/Low Blood Pressure
- ☐ Hypoglycemia
- ☐ Kidney Problems
- ☐ Liver Disease/Hepatitis/Jaundice
- ☐ Mitral Valve Prolepses
- ☐ Nervous Disorder
- ☐ Pacemaker/Stents/Value Replacements
- ☐ Psychiatric Problems/Mental Disorder
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Severe/Frequent Headaches
- ☐ Shingles/Chicken Pox
- ☐ Sickle Cell Disease/Traits
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Temporalmandibular Joint Disorder (TMJ)
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis (TB) Type:_______________
- ☐ Tumors/Growths
- ☐ Ulcers/Colitis
- ☐ Venereal Disease

If you have any condition, problem, or disease not listed, what is it? ____

Dental History

Have you ever had a local anesthetic (e.g. Novocain)? ☐ Yes ☐ No
Have you ever had an unfavorable reaction to anesthetic? ☐ Yes ☐ No
Have you ever had serious trouble associated with dental treatment? ☐ Yes ☐ No
If yes, please explain? ____
Date of last full mouth x-rays (FMX/Pano)? __________________________ Date of last dental treatment? _________________________________
Does dental treatment make you nervous? ☐ Slightly ☐ Moderately ☐ Extremely
Would you desire to be pre-sedated? ☐ Yes ☐ No
How do you feel your current dental health is? ☐ Poor ☐ Fair ☐ Good ☐ Great
Do you like your smile? ☐ Yes ☐ No
If you could change your smile you would do:
☐ Whiter/Brighter ☐ Replace Missing Teeth ☐ Close Space/Straighter ☐ Repair chipped teeth ☐ Veneers/Crowns
☐ Other:____

Do you smoke? ☐ Yes ☐ No If yes, how much? _____________ Do you drink coffee or tea? ☐ Yes ☐ No If yes, how much? ___________

How often do you floss? ______________________ How often do you brush?_______________________
Do you have any of the problems listed below?:

Snoring Problem ☐ Yes ☐ No
Bad Breath ☐ Yes ☐ No
Other ☐ Yes ☐ No
Bleeding Gums ☐ Yes ☐ No
Grinding Teeth ☐ Yes ☐ No

Consent for Treatment

To the best of my knowledge all of the preceding answers are true and correct. If I have any changes in my health or if my medications change, I will inform the doctor at my next appointment. I hereby grant authority to the dentist(s) in charge of the care of the person whose name appears on this form to administer such anesthetics, analgesics, and sedatives' and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, and anesthetics, and/or drugs. All services are rendered and accepted under the terms and conditions presented and agreed to at the top of this form. This authorization must be signed by the patient, or legal guardian in the case of a minor, or when the patient is mentally or physically incompetent.

____ ____________________________
Patient's Signature (If minor, Parent or Legal Guardian) Date

____
Patient's Signature (If minor, Parent or Guardian's Print Name)

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I, Dr.________________ have verbally reviewed the medical/dental information above with the patient/parent/guardian named herein.
Doctor's Comments:____

Date:	B.P:	Pulse:	Taken By:	Reviewed By: