Date _____ Chart #_____ Like us on Facebook!

Patient Information

Referring Doctor _____

Name _____ Street Address _____

P.O. Box _____ City _____ State _____ Zip _____ ***County*** _____

Home Phone _____ Cell # _____

Email _____

Employer _____ Work # _____

Birthdate _____ Sex: M ___ F___ Single_____ Married____ Divorced ____ Widowed____

Social Security # _____ Full time student? _____ Where? _____

Emergency Contact _____ Relation to Patient _____ Phone _____

Preferred Communication (Check any that apply) ☐ Phone ☐ Text ☐ Email

Responsible Party

Signature _____

Name _____ Street Address _____

P.O. Box _____ City _____ State _____ Zip _____ ***County*** _____

Home Phone _____ Work 1 _____ Work 2 _____

Birthdate _____ Sex: M ___ F___ Single_____ Married____ Divorced ____ Widowed____

Social Security # _____ Driver License # _____

Dental Insurance Information (Not Medical or Medicare)

Name of Insured _____ Address _____

City _____ State _____ Zip _____ ***County*** _____

Home Phone _____ Work 1 _____ Work 2 _____

Birthdate _____ Sex: M____ F _____

Social Security # _____ Relationship to Patient _____

Employer _____ Group Number _____ Effective Date of Coverage _____

Insurance Company _____ Phone _____

Address _____ City _____ State_____ Zip_____

Secondary Dental Insurance Information

Name of Insured _____ Address _____

City _____ State _____ Zip _____ ***County*** _____

Home Phone _____ Work 1 _____ Work 2 _____

Birthdate _____ Sex: M____ F _____

Social Security # _____ Relationship to Patient _____

Employer _____ Group Number _____ Effective Date of Coverage _____

Insurance Company _____ Phone _____

Address _____ City _____ State_____ Zip_____

ADULT EXAMINATION AND HEALTH HISTORY QUESTIONNAIRE

All information given on this form is for our records only and will be considered confidential.

1. Are you experiencing pain from your mouth at this time?_____ If so, explain: _____
2. How many times have you had your teeth cleaned in the last 5 years?_____ When was the last time? _____
3. Have you had previous periodontal (gum) treatment?_____ Dentist, date _____
4. Did either your mother, father, brother, or sister lose all of their natural teeth?_____ If so, when? _____
5. Are your teeth sensitive to heat or cold, or sweets?_____ Which ones?_____
6. Have you had your teeth straightened?_____ Date:_____ Dentist: _____
7. Have you been under more stress than average lately?_____
8. Do you smoke?_____ What and how much? _____
9. Are you aware of grinding your teeth at night in your sleep?_____ Do you clench your teeth together?_____
10. Have we treated any of your family or friends?_____ Who? _____
11. How did you find our practice? ☐ Referring Doctor ☐ Friend or Family ☐ Internet Search ☐ Other

Date

(continued on next page)

PATIENT INFORMATION
HEALTH QUESTIONNAIRE

MEDICAL ALERT

12. Do you consider your general health to be good?_____ Fair?_____ Poor?_____
13. Has your general health changed within the past year?_____ Explain:_____

_____

14. Have you ever fainted?_____ In a dental office? _____
15. Are you taking any medications / drugs / pills regularly?_____ If so, list name and amount of dosage: _____

_____

_____

16. Physician's Name _____Date Last Seen _____
17. Are you being treated by a physician at this time?_____ If so, why?_____

_____

18. Do you tire easily?_____ When? _____
19. List all childhood diseases (e.g., chicken pox, measles, rheumatic fever, etc.): _____

_____

20. Have you ever had, or do you have, any of the following?

☐ AIDS or HIV Positive	☐ Chemotherapy	☐ Heart valve replacement	☐ Organ Transplant	☐ Stroke
☐ Anemia	☐ Circulatory problems	☐ Heart murmur	☐ Prothesis/joint replacement	☐ Sulfa drugs
☐ Arthritis	☐ Clotting problems	☐ Hepatitis (A, B, C)	☐ Prosthetic Implants	☐ Thyroid disease
☐ Asthma	☐ Diabetes	☐ High/Low Blood Pressure	☐ Psychiatric treatment	☐ Tuberculosis
☐ Bladder trouble	☐ Epilepsy	☐ Kidney trouble	☐ Radiation therapy	☐ Ulcer(s)
☐ Bleeding problems	☐ Excessive Thirst	☐ Liver trouble	☐ Rheumatic Fever	☐ Venereal disease
☐ Blood disease	☐ Gland trouble	☐ Lung trouble	☐ Rheumatism	☐ Other
☐ Bowel Disease	☐ Glaucoma	☐ Malignancy	☐ Sinus trouble	
☐ Chemical dependency	☐ Heart disease	☐ Mitral valve prolapse	☐ Skin disease	

21. Have you ever taken cortisone?_____ When, and for how long? _____
22. Have you ever taken anticoagulants (blood thinners)?_____ When, and for how long? _____
23. Do you take an aspirin daily? _____
24. Have you ever been told to take antibiotics prior to dental treatment:_____
25. Have you ever been told that you have a heart murmur?_____
26. Circle or note the drug(s) you are allergic to or have reacted adversely to:

Antibiotics	Barbiturates	Darvon	Local (dental) Anesthetics	Penicillin
Antihistamines	Codeine	Demerol	Novocaine	Sulfa Drugs
			Latex	Versed/Valium
Aspirin/Ibuprofen	Other _____			

27. Do you bruise easily? _____
28. Have you had major surgery?_____When?_____ Any complications? _____

    For what?_____List any surgeries you have had: _____

_____

29. Are you on a special diet, to lose weight, low salt, diabetic, cholesterol, food allergy?_____
30. Have you gained _____ or lost _____ weight recently? How much?_____
31. Do you take vitamins, mineral supplements? _____
32. Women: Are you pregnant? _____ Which month? _____ Oral contraceptives?_____

    Have you reached menopause? _____ Are you taking hormones? _____
33. Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your periodontal care. Do you have <u>any</u> disease, condition or problem not listed above that we should know about? If so, explain: _____

_____

_____

_____

_____ _____

Signature of Patient Date