CONFIDENTIAL PATIENT HISTORY

Date_____

Name_____ Prefer to be called_____
Last First MI

Complete Mailing Address_____ zip_____
Employer / Address_____ zip_____
Birth Date_____ Home Phone_____
Social Security #_____ Work Phone_____
Email Address_____ Cell Phone_____
Whom may we thank for referring you?_____

Responsible party/spouse information: (fill out if patient is a minor or if spouse insurance is involved)
Name_____ Cell Phone_____
Relationship to patient_____ Work Phone_____
Employer / Address_____ zip_____
Birth Date_____ Social Security or ID #_____
If patient is a full time student, what is the name of the school?_____
Grade____ City and State_____

Do you now have, or have you ever had any of the following? Please check the appropriate boxes.

☐☐	Heart Disease/Surgery		☐☐	Emphysema	
☐☐	Artificial Valve		☐☐	Asthma	
☐☐	Heart Attack/Failure		☐☐	Eating Disorder	
☐☐	Artificial Joint		☐☐	Frequent Cough	
☐☐	Abnormal Blood Pressure		☐☐	Cold Sores/Fever Blisters	
☐☐	Stroke		☐☐	Epilepsy/Seizures	
☐☐	Blood Clotting Disorder		☐☐	Fainting/Dizziness	
☐☐	Cancer/Radiation/Chemo		☐☐	Pacemaker	
☐☐	Traumatic Accident		☐☐	Headaches	
☐☐	Arthritis/Sore Joints		☐☐	GERD/Acid Reflux	
☐☐	HIV Positive, ARC, or AIDS		☐☐	Sleep Apnea	
☐☐	Hepatitis (circle) A, B, or C		☐☐	Diabetes	
☐☐	Chemical Dependency		☐☐	Tuberculosis	

Have you ever had any other serious illness not checked above? _____

Are you allergic to any drugs, medications, or latex rubber? Please List:_____
Physician name and phone: _____

Primary reason for your visit:_____ Date of your last dental visit: __/__/__

Have you ever been instructed to take antibiotics before any dental or surgical procedure? Y/N

Are you currently taking **any drugs or medication**? Y/N

Please list the medication purpose. _____

_____

Have you been hospitalized or undergone any major surgery in the past five years? Y/N

If so, please give details and dates._____

Women: Do any of the following apply? ❒ Pregnant (due date:__/__/__) ❒ Trying to conceive ❒ Nursing

Have you ever had any serious problems associated with previous dental treatment? Y/N

If so, please explain._____

Have you ever been diagnosed or treated for periodontal (gum) disease? Y/N

Have you been concerned about bad breath, unpleasant odor or taste in your mouth? Y/N

Do you feel sensitivity with any of your teeth when brushing or flossing them? Y/N

Are there any swellings, growths, inflamed areas, or unhealed injuries in your mouth? Y/N

Does food catch between your teeth? Where:_____

Is any part of your mouth sensitive to temperatures, biting pressure, sweets? Y/N

When was your last cavity/restoration _____

Do you have a history of dry mouth? Y/N

How many times per day do you consume candy, breath mints, soda, sports drinks, or other sweets?

0-1 1-2 2+

Have you had orthodontic treatment or bite adjustments? Y/N

Do you have unreplaced missing teeth? Y/N

If so, why have you chosen not to replace them?_____

Have you noticed any movement, shifting, or change in your teeth? Y/N

Have you had locking or clicking in your jaw, inability to open wide or chew tough foods? Y/N

Do you awaken with the awareness of your teeth and jaws? Y/N

Do you clench and/or grind your teeth during the day or night? Y/N

Is there anything you would like to change about the appearance of your smile?_____

_____ Y/N

Do you have any pain around your eyes, ears, nose, neck, or mouth? Y/N

If so, where and how often?_____

How often do you get headaches?_____ neck aches?_____

Do you snore? Y/N

Do you wake up frequently or have trouble falling asleep? Y/N

Do you have a history of extensive dental treatment? Y/N

Has it been due to: ❒ new cavities ❒ gum disease ❒ replacement of dental work

Do you want to keep your remaining teeth? Y/N

Please add anything you feel important: _____

_____

_____

Name and phone number of someone not living with you to contact in case of emergency:

_____

Authorization

I understand that I am responsible for all costs of dental treatment. Payment is due at time of services. If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month, which is 18% applied annually to the last month's balance. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office otherwise payable to me. A copy of the dental materials fact sheet and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical history and other information about my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment I will give a minimum of **48** hours noticed or I will be responsible for the charge for time reserved.

Signature: _____ Date:_____