CONFIDENTIAL PATIENT HISTORY

Date_____

Name_____ Prefers to be called_____
Last First M.I.

Complete Mailing Address_____zip_____

Employer / Address_____zip_____

Birth Date_____ Home phone _____

Social Security #_____ Work phone_____

Cell phone _____

Whom may we thank for referring you? _____

Responsible party/spouse information: (fill out if patient is a minor or if spouse's insurance is involved)

Name_____ Cell Phone_____

Relationship to patient_____ Work Phone_____

Employer / Address _____zip_____

Birth Date_____

Social Security # _____

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.

Y	N	Description	Date	Y	N	Description	Date
☐	☐	Heart Disease/Surgery		☐	☐	HIV Positive, ARC, or AIDS	
☐	☐	Heart Murmur		☐	☐	Hepatitis (circle) A, B, or C	
☐	☐	Mitral Valve Prolapse		☐	☐	Chemical Dependency	
☐	☐	Heart Attack/Failure		☐	☐	Diabetes	
☐	☐	Artificial Joint/ Heart Valve		☐	☐	Tuberculosis	
☐	☐	Abnormal Blood Pressure		☐	☐	Emphysema	
☐	☐	Stroke		☐	☐	Asthma	
☐	☐	Blood Clotting Disorder		☐	☐	Eating Disorder	
☐	☐	Cancer		☐	☐	Frequent Cough	
☐	☐	Radiation Treatment		☐	☐	Cold Sores / Fever Blisters	
☐	☐	Chemotherapy		☐	☐	Epilepsy / Seizures	
☐	☐	Recent Blood Transfusion		☐	☐	Fainting / Dizziness	
☐	☐	Traumatic Accident		☐	☐	Pacemaker	
☐	☐	Rheumatic Fever		☐	☐	Headaches	
☐	☐	Arthritis / Sore Joints		☐	☐	GERD/Acid Reflux	

Have you ever had any other serious illness not checked above? If so, discuss: _____

_____

Physician name and phone:_____

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 and its purpose. _____

_____

Are you allergic to any drugs, medications, or latex rubber? Please list: _____

Have you been hospitalized or undergone 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?

Primary reason for visit:_____ When was your last dental visit: _____

For what reason do you usually come to the dentist? _____

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 or around your mouth? Y/N

Does food catch between your teeth? Where: _____

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

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 or grind your teeth during the day or night? Y/N

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

If so, where & how often? _____

How often do you get headaches? _____ Neckaches? _____

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 the time of services. 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 histories 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 notice or I will be responsible for the charge for time reserved.

Signature: X_____ Date: _____