

GENERAL HEALTH INFORMATION CHART # _____

DATE: _____

PATIENT NAME: _____ BIRTH DATE: _____ AGE: _____
LAST FIRST

DENTAL HISTORY

1. Reason for Visit / Main Concern? Check-Up Cleaning Toothache Other _____
2. Are there other conditions of which we should be aware? YES NO If yes, please specify: _____
3. When did you last visit a dentist? _____ 4. What treatment was performed? _____
5. Was the treatment completed? _____ 6. When were dental x-rays taken? _____
7. Did you have a cleaning ? YES NO 8. Have you had gum (periodontal) treatment? YES NO
9. Have you ever had prolonged bleeding after an extraction? YES NO If yes, please specify: _____
10. Have you had any problems with past dental treatment? YES NO If yes, please specify: _____
11. Do you grind your teeth, clench your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open? YES NO If yes, please specify: _____
12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ? YES NO If yes, please specify: _____
13. Do your gums bleed easily? YES NO 14. Do you feel you have bad breath? YES NO
15. Are your teeth sensitive to hot or cold? YES NO 16. Would you like your teeth whiter? YES NO
17. Are you happy with your smile? YES NO If no, please explain: _____

MEDICAL HISTORY

1. Are you under a Doctor's care at this time? YES NO If yes, please specify: _____ Dr. Name: _____
Dr. Phone: () _____
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? _____
3. Are you taking any medications at this time, including birth control? YES NO If yes, please specify: _____
4. (Women) Are you pregnant now? YES NO If yes, how many months? _____ Are you nursing? YES NO
5. Are there any other health problems of which we should be advised? Please specify: _____
6. Do you have, or have you had, any of the following?

Please check "YES" or "NO"	Doctor Comments	Please check "YES" or "NO"	Doctor Comments
ARTIFICIAL HEART VALVE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	HEPATITIS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
AIDS/HIV+ YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	HIGH BL. PRESSURE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ANEMIA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	JAUNDICE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ANGINA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	JOINT REPLACEMENT YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ARTHRITIS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	KIDNEY DISEASE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ASTHMA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LATEX ALLERGY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
BISPHOSPHONATE THERAPY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LIVER PROBLEMS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
BLEEDING PROBLEMS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LOW BL. PRESSURE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
CANCER YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LUNG DISEASE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
CHEMO/RAD THERAPY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	PACEMAKER YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
COSMETIC SURGERY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	PSYCHIATRIC CARE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
DIABETES YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	RHEUMATIC FEVER YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
DIZZY SPELLS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	SINUS TROUBLE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
DRUG ADDICTION YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	SLEEP APNEA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
EMPHYSEMA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	TOBACCO YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
EPILEPSY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	STROKE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
FAINTING YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	THYROID PROBLEMS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
GLAUCOMA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	TMD OR TMJ YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
HEART ATTACK/SURGERY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	TUBERCULOSIS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
HEART MURMUR/PROBLEMS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	VENEREAL DISEASE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.

Patient's signature _____ Date _____
(Parent if Patient is a Minor)

Doctor Signature _____

MEDICAL UPDATE:

1. Patient's signature _____ Doctor's Signature _____ Date _____
2. Patient's signature _____ Doctor's Signature _____ Date _____
3. Patient's signature _____ Doctor's Signature _____ Date _____

PATIENT INFORMATION

CHART # _____

PATIENT

Name _____
Last First

Address _____ Apt. # _____

City _____ Zip _____

How long at this address? _____

Phone () _____

Cell/Pager () _____

E-mail _____

Social Security # _____

DL# _____

Age _____ Birthdate _____

RESPONSIBLE PARTY (If same as above, please skip)

Name _____
Last First

Address _____ Apt. # _____

City _____ Zip _____

How long at this address? _____

Phone () _____

Social Security # _____ DL# _____

Relationship to Patient _____

Age _____ Birthdate _____

EMPLOYMENT

Occupation _____

Employer _____

How Long? _____

Business Address _____

City _____ Zip _____

Business Phone () _____ Ext. # _____

Verified By _____ Date _____

(Office use only)

REFERENCES

Name _____
Last First

Phone () _____

Name _____

Phone () _____

Spouse's Name _____
Last First

Spouse's Work Phone () _____

PERSON TO CONTACT FOR EMERGENCY:

Last First

Phone () _____

Physician _____ Phone () _____

GETTING TO KNOW YOU

What do you like to do in your free time?

1: _____ 2: _____

3: _____ 4: _____

How did you hear about our office? (Circle one)

Family-Friend (400)

Confidante (440)

Newspaper (470)

Billboard (050)

Flyer-Coupon (490)

Office Sign (420)

Office Transfer (430)

Insurance Plan (460)

Television (020)

Radio (030)

Yellow Pages (120)

Direct Mail-Postcard (480)

Internet-Website (190)

I want information in Spanish: YES _____ NO _____

INSURANCE / DENTAL PLAN

Primary: Insurance PPO HMO (Circle one)

Plan Name _____

Address _____

City, Zip _____

Insurance / Plan Phone # _____

Employer _____

Union/Local _____ Group # _____ Plan# _____

Insured's Name _____

Insured's Soc. Sec. # _____ Birthdate _____

INSURANCE / DENTAL PLAN

Secondary: Insurance PPO HMO (Circle one)

Plan Name _____

Address _____

City, Zip _____

Insurance / Plan Phone # _____

Employer _____

Union/Local _____ Group # _____ Plan# _____

Insured's Name _____

Insured's Soc. Sec. # _____ Birthdate _____

1. I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.
2. By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
3. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
4. I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

Signature of Responsible Party or Patient
(Parent if Patient is a Minor)

Date