PATIENT INFORMATION & HEALTH HISTORY

Legal Name:_______________________________________ Male / Female Birthdate:_____________ Age: ____

By what name would you prefer to be called?________________________________Marital Status: S M D W

Local Address____ Local Phone:____________

STREET CITY STATE ZIP

Social Security #_______________________ Occupation____________________ Cell Phone:______________

Employer____________________________ Can we call you at work? ☐Yes ☐No Work Phone:_____________

Friend or relative that will be available during your appointments:______________________ Phone:______________

Person responsible for your account if other than yourself:

Name_____________________________Birthdate:____________ Relationship to patient_______________

Address____ Phone:_________________

STREET CITY STATE ZIP

Social Security #__________________________________

May we notify this person concerning your diagnosis, treatment, and costs? ☐Yes ☐No

Account to be paid by: ☐ Cash ☐ Check ☐ MasterCard / Visa / Discover

PRIMARY DENTAL INSURANCE

Subscriber Name__________________________

Employer________________________________

S.S.N._________________D.O.B.___________

Insurance Carrier___________________________

SECONDARY DENTAL INSURANCE

Subscriber Name____________________________

Employer_________________________________

S.S.N.____________________D.O.B.__________

Insurance Carrier_____________________________

Please be aware that your dental insurance probably will not pay for the entire amount of your treatment. We cannot always predict your coverage and therefore we request that you pay for your treatment at each visit and collect reimbursement from your insurance company. We will provide your insurance company with any information necessary for you to receive your benefits and reimbursement. You are responsible for any charges not paid by your dental and/or medical insurance.

DENTAL INFORMATION

Who Referred You To Our Office:____

Reason For Today's Visit:____

____

Previous Dentist:____

NAME STREET CITY STATE ZIP PHONE

Yes	No	
☐	☐	Do your gums bleed when you brush?
☐	☐	Are your teeth sensitive to cold, hot, sweets or pressure?
☐	☐	Have you had any periodontal (gum) treatments?
☐	☐	Have you had orthodontic (braces) treatment?
☐	☐	Do you have headaches, ear, or neck pain?
☐	☐	Do you wear removable dental appliances?

Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain________________________

____

Date of your last dental exam:____Date of last dental x-rays________________________

What was done at that time?____

How do you feel about the appearance of your teeth?____

Have you ever whitened or lightened your teeth?____

Please list anything else you feel is important for us to know.____

____

____

____

Do you wish to discuss anything about your medical or dental history with the doctor in private? ☐ Yes ☐ No

PLEASE COMPLETE THE BACK OF THIS FORM, THEN RETURN TO RECEPTIONIST

MEDICAL INFORMATION

Yes No
☐ ☐ Are you in good health?
☐ ☐ Has there been any change in your general health within the past year? Explain___________________________________
☐ ☐ Are you now under the care of a physician? If so, what is/are the condition(s) being treated: ________________________
____
Date of your last physical exam:_____________ Your physician's name(s):_______________________________________
☐ ☐ Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so what was the illness or medical problem:____
☐ ☐ Are you taking, or have recently taken any medicine(s) including non-prescription medication? *Please list those medicines:*
____
____

(WOMEN ONLY) Yes No
☐ ☐ Pregnant or could be? ☐ ☐ Are you nursing? ☐ ☐ Birth Control Pills
☐ ☐ Hormone Replacement (HRT)? ☐ ☐ Ever taken bisphosphonates for osteoporosis? (ie Fosamax,Boniva)

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

Yes No
☐ ☐ Abnormal bleeding
☐ ☐ AIDS or HIV infection
☐ ☐ Anemia
☐ ☐ Arthritis
☐ ☐ Rheumatoid Arthritis
☐ ☐ Asthma
☐ ☐ Blood Transfusion
*If yes, date*___________
☐ ☐ Cancer
☐ ☐ Chemotherapy or Radiation
☐ ☐ Cardiovascular Disease disease
If yes, check all that apply:
☐ Angina
☐ Arteriosclerosis
☐ Artificial Heart Valve
☐ Coronary Insufficiency
☐ Coronary Occlusion
☐ Damaged Heart Valve
☐ Heart Attack
☐ Heart Murmur
☐ High Blood Pressure
☐ Inborn(congenital)Heart Defect
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Rheumatic Heart Disease
☐ ☐ Chest Pain upon exertion
☐ ☐ Chronic Pain
☐ ☐ Persistent diarrhea

Yes No
☐ ☐ Immunosuppressed
☐ ☐ Diabetes
☐ Type I (Insulin dependent)
☐ Type II
☐ ☐ Dry Mouth
☐ ☐ Eating Disorder
*If yes, specify*___________
☐ ☐ Epilepsy / Seizures
☐ ☐ Fainting Spells
☐ ☐ G.I. gastric reflux
☐ ☐ Glaucoma
☐ ☐ Hemophilia
☐ ☐ Hepatitis, jaundice, liver disease
☐ ☐ Recurrent Infections
if yes, please specify:
____
☐ ☐ Low Blood Pressure
☐ ☐ Kidney problems
☐ ☐ Mental Health Disorders
*specify:*________________
☐ ☐ Drug / Alcohol dependence
☐ ☐ Prosthetic joint
If yes, please specify which joint and date of surgery
____
☐ ☐ Malnutrition
☐ ☐ Migraine headaches
☐ ☐ Night Sweats

Yes No
☐ ☐ Neurological disorders
*specify:*______________
☐ ☐ Osteoporosis
☐ ☐ Persistent swollen glands
☐ ☐ Respiratory problems
☐ Emphysema
☐ Bronchitis
☐ Other____________
☐ ☐ Severe headaches
☐ ☐ Unusual weight change
☐ ☐ Sexually transmitted
☐ ☐ Sinus problems
☐ ☐ Sleep disorders
☐ ☐ Sores or ulcers in mouth
☐ ☐ Stroke
☐ ☐ Systemic Lupus Eryth.
☐ ☐ Thyroid problems
☐ ☐ Tuberculosis
☐ ☐ Ulcers
☐ ☐ Excessive urination
☐ ☐ Do you have any disease, condition, or problem that we should know about?
*Explain:*_____________________
____
____
____
____

Are you ALLERGIC, or had a bad REACTION to:

Yes No
☐ ☐ Local anesthetics (Novocaine)
☐ ☐ Aspirin
☐ ☐ Foods:____________________
☐ ☐ Metals:____________________
☐ ☐ Other :____________________

Yes No
☐ ☐ Penicillin
☐ ☐ Sulfa drugs / Sulfonamides
☐ ☐ Other Antibiotics__________
☐ ☐ Preservatives / Additives

Yes No
☐ ☐ Iodine
☐ ☐ Codeine / Narcotics
☐ ☐ Latex
☐ ☐ Hay fever/Seasonal

*If "yes" to any allergy, explain type of reaction:*______________________
____

Additionally, I hereby authorize payment of the dental benefits otherwise payable to me , directly to Drs. Phipps, Levin, Hebeka, & Associates, Ltd.

Date	**Signature of Patient (Guardian)**	comments	office use
__________	________________________________	____________________________	______
__________	________________________________	____________________________	______
__________	________________________________	____________________________	______
__________	________________________________	____________________________	______