PATIENT INFORMATION & HEALTH HISTORY

Legal Name:__________ Gender:____ Birthdate:______ Age: ___

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

Local Address__________ (STREET, CITY, STATE, ZIP) Local Phone:______

Social Security #______ Occupation______ Cell Phone:______

Employer__________ 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__________ (STREET, CITY, STATE, ZIP) Phone:______

Social Security #__________

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Subscriber Name______	Subscriber Name______
Employer______	Employer______
S.S.N.______ D.O.B.______	S.S.N.______ D.O.B.______
Insurance Carrier______	Insurance Carrier______
ID #:______ Group#:______	ID #:______ Group#:______
Address:______	Address:______
Phone#:______	Phone#:______

DENTAL INFORMATION

Who Referred You To Our Office:__________

Reason For Today's Visit:__________

Previous Dentist:__________ (Name, Street, City, State, Phone)

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

<u>PLEASE COMPLETE THE BACK</u> OF THIS FORM, THEN RETURN TO RECEPTIONIST

MEDICAL INFORMATION

Yes No

☐ ☐ Has there been any change in your general health in the last year? If yes, please explain: ______

☐ ☐ Are you under the care of a physician? Condition(s) being treated: ______

Date of your last physical exam: ______ Your physician's name: ______

☐ ☐ Have you had any illness, operation or been hospitalized in the last 5 years? If so, please list the illness or medical problem: ______

☐ ☐ Are you taking any medications? Please list all medications you are taking: ______

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(s): ______
☐ ☐ Cancer
If yes, type(s): ______
☐ ☐ Chemotherapy or Radiation
☐ ☐ Cardiovascular 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 1 (Insulin Dependent)
☐ Type 2
☐ ☐ Dry Mouth
☐ ☐ Eating Disorder
If yes, please specify ______
☐ ☐ Epilepsy/Siezures
☐ ☐ Fainting Spells
☐ ☐ GERD
☐ ☐ Glaucoma
☐ ☐ Hemophilia
☐ ☐ Hepatitis, Jaundice, Liver Disease
☐ ☐ Recurrent Infections
If yes, please specify: ______
☐ ☐ Low Blood Pressure
☐ ☐ Kidney Problems
☐ ☐ Mental Health Disorders
Please specify: ______
☐ ☐ Drug/Alcohol Dependence
☐ ☐ Prosthetic Joint
If yes, please specify which joint and date of surgery: ______
☐ ☐ Malnutrition
☐ ☐ Migraine Headaches
☐ ☐ Neurological Disorders
Please specify: ______

Yes No

☐ ☐ Osteoporosis/Osteopenia
If yes, have you ever taken a Bisphosphonate? (Fosamax/Boniva)
☐ *Yes* ☐ *No*
☐ ☐ Persistent Swollen Glands
☐ ☐ Respiratory Problems
☐ *Emphysema*
☐ Bronchitis
☐ Other ______
☐ ☐ Severe Headaches
☐ ☐ Unusual Weight Change
☐ ☐ Sexually Transmitted Disease
☐ ☐ Sinus Problems
☐ ☐ Sleep Disorders
☐ ☐ Sores or Ulcers in the Mouth
☐ ☐ Stroke
☐ ☐ Systemic Lupus Eryth.
☐ ☐ Thyroid Problems
☐ ☐ Tuberculosis
☐ ☐ Ulcers
☐ ☐ Excessive Urination
☐ ☐ Do you have any disease, condition or problem that we should know about?
Please explain: ______

WOMEN ONLY:

Yes No

☐ ☐ *Pregnant or could be?*
☐ ☐ Are you nursing?

Are you ALLERGIC to, or had a bad REACTION to:

Yes No

☐ ☐ Local Anesthetics (Novocaine)
☐ ☐ Codeine/Narcotics
☐ ☐ Metals: ______
☐ ☐ Other: ______

Yes No

☐ ☐ Penicillin
☐ ☐ Foods: ______
☐ ☐ Preservatives/Additives

Yes No

☐ ☐ Sulfa Drugs/Sulfonamides
☐ ☐ Latex
☐ ☐ Hay Fever/Seasonal

If yes to any allergy, please explain the type of reaction: ______

Please Initial

______ **We will provide your insurance company with any information necessary for you to receive the maximum benefits and reimbursements that your dental insurance will allow. You are responsible for any charges not paid by your insurance. We request that you pay your ESTIMATE for treatment at each appointment.**

______ **Missed Appointment Policy: If an appointment has been missed or canceled, with less than 24 hours notice, a fee may be applied. For Monday appointments, cancellations should be made by noon on the preceding Friday.**

By signing below, I hereby authorize payment of the dental benefits directly to Phipps, Shevlin, Hebeka General Dentistry.

Date ______ **Signature of Patient or Guardian** ______ **Comments** ______