Adult Patient Information

Patient's Name _____ Today's Date _____

Home Address _____

City_____ Zip_____ DL #_____

Social Security # _____-_____-_____ Date of Birth _____/_____/_____ Age_____ Marital Status S/M/D/W

Your Occupation_____Employer_____ Cell #_____

Email address: _____

Spouse's Name_____ Social Security # _____-_____-_____

Your spouse's Date of Birth____/____/____Employer_____

Person to contact in an emergency_____ Relation_____

Cell Tel#: _____ Email Address _____

Party responsible for account _____ Cell Tel.# _____

Email: _____

Whom may we thank for referring you? _____

Google: _____ **Internet:** _____

DENTAL HEALTH HISTORY

For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out all areas which pertain to you. ALL INFORMATION IS KEPT CONFIDENTIAL

Dental History:

Previous Dentist_____ City_____ How long_____

Date of last visit_____ Date of last dental cleaning_____ Date of last full mouth x-ray _____

1. Why did you leave your last dentist?_____
2. What did you like most about any dentist, or a dental office you have been to?_____
3. What did you like least about any dentist, or dental office that you have been to?_____

INSURANCE INFORMATION

Insured _____ Insured's SS# _____-_____ -_____Insured's DOB _____-_____-_____

Insurance Co. _____ Insurance Co. Tel _____ Group # _____

SECONDARY INSURANCE INFORMATION

Insured _____ Insured's SS# _____-_____ -_____Insured's DOB _____-_____-_____

Insurance Co. _____ Insurance Co. Tel _____ Group # _____

If you could change one thing about your smile, what would that be? _____

_____

If there was a simple, inexpensive way to whiten your teeth, would you be interested? Y N

Do you want to keep your teeth? ____ Yes, no matter how much trouble ____ I don't know

____ Yes, if it's not too much trouble ____ I don't care

Patient Health History

Medical Health History:

1. Describe your present health ___ Excellent ___ Good ___ Fair ___ Poor
2. List your current Physician(s): a._____ Type_____
   b._____ Type_____
3. Date of your last physical exam _____/_____/_____ Purpose_____
4. Are you aware of any changes in your general health in the last year? No Yes _____
5. Have you been hospitalized for illness or surgery in the past two years? No Yes _____
6. Have you been under a medical doctor's care during the past two years? No Yes _____
7. Have you ever had excessive bleeding that required special treatment? No Yes _____
8. Are you on a special or restricted diet of any kind? No Yes _____
9. Do you smoke? ___ No ___ Yes How much?_____ How long? _____
10. Do you consume drinks with caffeine? ___ No ___ Yes How many?_____
11. Do you consume alcoholic drinks? ___ No ___ Yes How many drinks per day _____ per week_____
12. Are you taking blood thinners including aspirin? ___ No ___ Yes
13. List all medications you are now taking (include over the counter)_____

_____

List all medications you are allergic to: _____

Indicate which of the following you have had or presently have, circle yes or no:

A Nervous Person	No/Yes	Epilepsy or Seizures	No/Yes	Liver Disease	No/Yes
AIDS	No/Yes	Fainting or Dizzy Spells	No/Yes	Low Blood Pressure	No/Yes
Allergies or Hives	No/Yes	Frequent Headaches	No/Yes	Persistent Cough	No/Yes
Anemia	No/Yes	Frequent Thirst/Urination	No/Yes	Psychiatric Care	No/Yes
Angina	No/Yes	Glaucoma	No/Yes	Radiation Treatment	No/Yes
*Arthritis Rheumatism	No/Yes	Hay Fever	No/Yes	Rheumatic Fever	No/Yes
*Artificial Joint (Knee, Hip)	No/Yes	Heart Disease or Attack	No/Yes	Scarlet Fever	No/Yes
*Artificial Heart Valve	No/Yes	Heart Murmur	No/Yes	Shortness of Breath	No/Yes
Asthma	No/Yes	Heart Pacemakers	No/Yes	Sinus Trouble	No/Yes
Blood Transfusions	No/Yes	Heart Surgery	No/Yes	Stroke	No/Yes
Birth control pills	No/Yes	Heart Trouble	No/Yes	Taking hormone med.	No/Yes
Cancers or Tumors	No/Yes	Hemophilia	No/Yes	Thyroid Disease	No/Yes
Chemotherapy	No/Yes	Hepatitis	No/Yes	Tuberculosis	No/Yes
Congenital Heart Lesions	No/Yes	High Blood Pressure	No/Yes	Ulcers	No/Yes
Diabetes	No/Yes	HIV Positive	No/Yes	Weight Loss/Gain	No/Yes
Drug/Alcohol Addict	No/Yes	If female, are you pregnant?	No/Yes		
Emphysema	No/Yes	Kidney or Bladder Trouble	No/Yes		

*** If yes to any of starred conditions please call prior to appointment.**

Do you have any medical conditions or diseases we should know about? No/Yes

Explain: _____

To the best of my knowledge, all the preceding answers are true and correct. If I have any changes in my health or medicines, I will inform the Doctor on or before my next appointment, without fail.

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____