PATIENT INFORMATION

Name _____ ❑ Married ❑ Single ❑ Widow/er ❑ Male ❑ Female
Residence _____ City _____ State _____ Zip _____
Birthdate _____ Age _____ Ht _____ Wt _____ Tel (Home) _____ (Office) _____
Occupation _____ Employer _____
Have we treated any of your family or friends? ❑ Yes _____ ❑ No
Where and when are best times to reach you? _____
Referred By _____ Your Social Security # _____

DENTAL INSURANCE

Primary Carrier
Insured's Name _____
Insurance Co. _____
Insurance Co. Address _____
Insured's Employer _____
Soc. Sec. # _____
Group # _____ Local # _____

If you have double dental insurance coverage, complete this for the second coverage.
Insured's Name _____
Insurance Co. _____
Insurance Co. Address _____
Insured's Employer _____
Soc. Sec. # _____
Group # _____ Local # _____

DENTAL/MEDICAL HISTORY

Yes	No	
		How long since you have seen your dentist? _____
❑	❑	Are you experiencing **pain** in your mouth at this time?
		How many times have you had your teeth **cleaned** in the last 5 years? _____
		When was the **last time?** _____
❑	❑	Have you had **previous periodontal treatments**? When? _____
❑	❑	Do your gums **bleed**?
❑	❑	Have you noticed any **loose** or **shifting** teeth?
❑	❑	Are your teeth **sensitive** to **heat, cold** or **sweets**? (circle)
		How often do you **brush** your teeth? _____ Floss? _____
❑	❑	Have you worn **braces** on your teeth? (orthodontics)
❑	❑	Have you noticed any mouth **odors** or **bad tastes**?
❑	❑	Are you aware of **grinding** or **clenching** your teeth?
❑	❑	Do you have **clicking, popping** or **pain** in your jaw joint?
❑	❑	Would you like your smile to **look better** or **different?**
❑	❑	Would you be tremendously **disturbed** if you had to **lose** your teeth?
❑	❑	Have you been under more **stress** than average lately?
		Please rank the following in the order in which they would keep you from having periodontal treatment.
		# Fear of pain # Cost # Lack of concern # Missing work time
❑	❑	Are you currently under the care of a **Physician**? For What? _____
❑	❑	Have you had any medical **treatment** of any kind in the last two years?
		Describe _____
		Name of your medical **doctor(s)** _____

DENTAL/MEDICAL HISTORY, Continued

Yes	No	
❑	❑	Have you ever had major **surgery**?

When? _____ What type _____ Any complications? _____

Do You **smoke**? _____ How much? _____

Your current **physical health** is ❑ Good ❑ Fair ❑ Poor

❑ Heart Attack/Stroke	❑ Sinus Problems	❑ Cortisone Medicine
❑ Angina Pectoris	❑ Difficult Breathing	❑ HIV +/ AIDS
❑ High/Low Blood Pressure	❑ Asthma	❑ Ulcers
❑ Heart Murmur	❑ Lung Trouble	❑ Anorexia, Bulimia
❑ Rheumatic Fever	❑ Tuberculosis (T.B.)	❑ Fever Blisters
❑ Mitral Valve Prolapse	❑ Liver Trouble	❑ Artificial Joints (Hip, Knee)
❑ Hemophilia	❑ Hepatitis	❑ Alcoholism
❑ Transfusions	❑ Bladder Trouble	❑ Chemical Dependency
❑ Bruise Easily	❑ Kidney Trouble	❑ Frequent Headaches
❑ Bleeding Problems	❑ Gland Trouble	❑ Diabetes
❑ Clotting Problems	❑ Cancer/Chemotherapy	❑ Epilepsy/Seizures
❑ Anemia	❑ Sexually Transmitted Disease	❑ Psychiatric Treatment

Have you ever had an **allergic reaction** or been told not to take any medications? If yes, describe _____

_____

Are you currently taking any **nonprescription** drugs of any kind (Example: Aspirin, Tylenol, Cough Syrup, Nasal Spray, Recreational Drug Use)? _____

Are you currently taking any **prescription** drugs of any kind? (Example: Birth Control, Hormones, Diet)?

If yes, what? _____

For Women: Are you **pregnant**? _____ Are you **nursing**? _____

Do you have any disease, condition or problem not listed? _____

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ _____

Signature Date

Our office is committed to meeting or exceeding the standards of INFECTION CONTROL mandated by OSHA, the Ohio State Dental Board and the ADA.

OFFICE USE:

I verbally reviewed the medical/dental information above with the patient named herein.

Doctor's Initials _____ Date _____

Doctor's Comments _____