# PATIENT DENTAL RECORD

Patient No: _____ Account No.: _____

*WE have the interest and desire to listen, really listen to what you are saying. Please do not hesitate to ask about anything you don not understand. You are dealing with members of a team whose primary job is to serve you. WE promise that you will never leave feeling that no one cares.*

In order to begin treatment, the following information is necessary. ***Please fully complete and print legibly***. All information, of course, will be held in strict confidence.

## PATIENT HISTORY INFORMATION

**Please PRINT**

PATIENT'S NAME: _____ CELL #: _____ *EMAIL ADDRESS:* HOME #: _____

SOC.SEC.No. _____ BIRTHDAY _____ AGE _____ SEX ____ MARITAL STATUS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PATIENT'S EMPLOYER _____ WORK PHONE _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY _____ PHONE _____

STUDENT: ☐ FULL TIME..... ☐ PART TIME..... SCHOOL _____ CITY _____

IS ANY CURRENT DENTAL PROBLEM THE RESULT OF AN ACCIDENT ☐ YES ☐ NO IF YES, WHEN? _____

## RESPONSIBLE PARTY'S INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT _____
**LAST** **FIRST** **MIDDLE**

RELATIONSHIP TO PATIENT _____ HOME PHONE _____ WORK PHONE _____

MAILING ADDRESS _____ CITY _____ ZIP _____

SOC.SEC.No. _____ DRIVER'S LICENSE No. _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____ CITY _____ ZIP _____

HAVE YOU OR ANY MEMBERS OF YOUR FAMILY BEEN A PATIENT BEFORE? ☐ YES ☐ NO
If YES, NAME _____ WHEN _____

**DENTAL INSURANCE:** ☐ **YES** ☐ **NO**

**INSURED'S NAME:** _____

**SSN/ID #** _____ DOB _____

EMPLOYER _____

**INS.Co or PLAN** _____

GROUP NAME _____

GROUP/POLICY # _____

**SECONDARY INSURANCE:** ☐ **YES** ☐ **NO**

**INSURED'S NAME:** _____

**SSN/ID #** _____ DOB _____

EMPLOYER _____

**INS.Co or PLAN** _____

GROUP NAME _____

GROUP/POLICY # _____

How did you hear about this office? ☐ Union ☐ Telephone Book ☐ Saw Building/Sign ☐ Employer ☐ Advertisements _____
☐ Former Patient (Who?_____) ☐ Website/Internet ☐ Insurance ☐ Other _____

WHY ARE YOU HERE TODAY? _____ (ie, Check up, Toothache, Consultation, ETC).

*This is to certify that I, the undersigned, consent to the performing of whatever dental services and/or surgical procedures may be decided upon to be necessary or advisable, and to the use of local or general anesthetic as may be deemed advisable by the dentist. I have also been explained the consequences of partial and/or no treatment. I hereby authorize my dentist to release any and all related information (including **dental information**) to the above named insurance carrier for purposes of claim administration and evaluation, utilization review and financial audit. This authorizes remains valid and effective from the date of signing until revoked in writing.*
*I hereby authorize my insurance carrier to pay directly to the within named dentist(s) the dental benefits otherwise payable to me.*

_____ _____
**PATIENT SIGNATURE** **DATE**

_____ _____
**RESPONSIBLE PARTY'S SIGNATURE** **DATE**

# PATIENT HEALTH HISTORY

These questions assure that treatment will take in to consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

**Please circle Yes or No for each question.** Thank You.

## MEDICAL HISTORY

- Are you in good health?..... Yes No
- Date of last physical examination _____
- Physician's Name:_____ City_____ Phone Number (____) _____
- Are you currently under the care of a physician? **If Yes, please explain** _____ Yes No
- Have you ever had any serious illness or operations or hospitalizations?..... Yes No
- If yes, please explain: _____
- Are you taking any medications? **If Yes, please list:** _____ Yes No
- Have you ever been pre-medicated with antibiotics for any dental treatment? ..... Yes No
- Are you allergic to: ☐ Penicillin ☐ Tetracycline ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine ☐Latex ☐ Metal ☐ Other..... Yes No
- Have you ever taken Fen-phen or similar weight control medications? _____ Yes No
- Have you ever taken /or taking: ☐Boniva ☐ Fosamax ☐ Bisphosphonate. If so, how long _____ Yes No

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? **PLEASE √ yes OR no for every item.**

| Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
|---|---|---|---|---|---|
| ☐ ☐Bells Palsy | ☐ ☐Cold Sores | ☐ ☐Sinus Trouble | ☐ ☐Blood Transfusion | ☐ ☐Mental Disorder | ☐ ☐High Blood Pressure |
| ☐ ☐Tonsillitis | ☐ ☐Herpes | ☐ ☐Thyroid Disease | ☐ ☐Excessive Bleeding | ☐ ☐Nervous Disorder | ☐ ☐Mitral Valve Prolapse |
| ☐ ☐Stroke | ☐ ☐Stomach Ulcer | ☐ ☐Low Blood Sugar | ☐ ☐Sickle Cell Disease | ☐ ☐Psychiatric Care | ☐ ☐Heart Valve Replacement |
| ☐ ☐HIV/AIDS | ☐ ☐Bruise Easily | ☐ ☐ Cerebral Palsy | ☐ ☐Artificial Prosthesis | ☐ ☐ Kidney Disease | ☐ ☐Angina Pectoris |
| ☐ ☐Diabetes | ☐ ☐ Rheumatic Fever | ☐ ☐ Fainting/Seizure | ☐ ☐Joint Replacement | ☐ ☐ Asthma | ☐ ☐Heart Attack/Ailment |
| ☐ ☐Glaucoma | ☐ ☐ Liver Disease | ☐ ☐ Epilepsy | ☐ ☐ Difficulty Swallowing | ☐ ☐Tuberculosis | ☐ ☐ Heart Pacemaker |
| ☐ ☐Arthritis | ☐ ☐Hepatitis | ☐ ☐Phys. Handicapped | ☐ ☐Hearing Impaired | ☐ ☐ Emphysema | ☐ ☐ Heart Murmur |
| ☐ ☐Anemia | ☐ ☐Blood Disease | ☐ ☐ TMJ Pain | ☐ ☐ Cancer/Chemotherapy | ☐ ☐ Radiation Treatment | ☐ ☐ Heart Surgery |
| ☐ ☐Chronic Back Pain | | ☐ ☐Chronic Headaches | | ☐ ☐Other_____ | |

1. Do you have any disease, conditions, or problems not listed that I should know about? ..... Yes No
2. Do you smoke or use any tobacco products? How much per day? ..... Yes No
3. (Women) Is there a possibility you may be pregnant? ..... Yes No
4. (Women) Do you have any problems associated with your menstrual period? ..... Yes No
5. (Women) Do you take birth control pills? ..... Yes No

## DENTAL HISTORY

- Previous Dentist_____ City_____ Phone _____
- Do you have any specific problems? If So, explain _____ Yes No
- Do you have or have you had any of the following? Please √ ..... Yes No

  ☐ Bad Breath ☐ Loose Teeth ☐ Headaches ☐ Bleeding Gums ☐ Sensitive Teeth ☐ Jaw Pops/Lock

  ☐ Sinus Trouble ☐ Injury ☐ Oral Surgery☐ Orthodontics ☐ Periodontics

  Please Explain: _____
- Are you participating in any sports? Which Sport? _____ Yes No
- Does dental treatment make you nervous? ☐ Slightly ☐ Moderately ☐ Severely ..... Yes No
- Have you ever had any unfavorable reaction from local anesthetics? ..... Yes No
- Have you had any serious trouble with any previous dental treatment? ..... Yes No
- How long since your last dental x-rays? _____ Dental Treatment?_____
- Would you prefer to be pre-sedated? ☐ Nitrous Oxide ☐ Oral Medications ☐ Conscious Sedation ..... Yes No

All of the preceding are true to the best of my knowledge. I will inform the doctor of any future changes.

**PATIENT/PARENT/GUARDIAN SIGNATURE:** _____ Date: _____

**DENTIST SIGNATURE:** _____ Date: _____

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**OFFICE USE ONLY:**

Changes in health/medications: _____

_____

**Date:**_____Patient/Signature_____ DDS/RDH: _____

Changes in health/medications: _____

_____

**Date:**_____ Patient/Signature_____ DDS/RDH_____