PATIENT INFORMATION AND HEALTH HISTORY

NAME ______ SINGLE MARRIED DIVORCED SEPARATED WIDOWED

NAME OF SPOUSE ______ HOME PHONE ______ CELL PHONE/BEEPER ______ YOUR SOCIAL SECURITY NO.

RESIDENCE ADDRESS ______ CITY ______ STATE ______ ZIP

EMPLOYED BY ______ CITY ______ STATE ______ BUSINESS PHONE

PRESENT POSITION ______ HOW LONG HELD ______ DATE OF BIRTH ______ AGE

SPOUSE EMPLOYED BY ______ CITY ______ STATE ______ PHONE

PRESENT POSITOIN ______ HOW LONG HELD

SPOUSE'S SOCIAL SECURITY NUMBER ______ WHO WILL PAY FOR THIS ACCOUNT?

WHOM MAY WE THANK FOR REFERRING YOU? ______ NAME OF YOUR DENTAL INSURANCE COMPANY

PURPOSE OF CALL: REGULAR CHECKUP ☐ SPECIFIC PROBLEM ☐

DENTAL HISTORY

DATE OF LAST DENTAL EXAM______ DATE OF LAST COMPLETE SET OF X-RAYS (18) ______

NAME OF PREVIOUS DENTIST ______ CITY OR TOWN______

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums. How long ______
- ☐ Food impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ☐ Unusual sounds in ear (ringing or buzzing)
- ☐ Frequent headaches
- ☐ Bad Breath
- ☐ Unpleasant taste
- ☐ Unfavorable dental experience
- ☐ Complications from extractions
- ☐ Periodontal surgery
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Oral habits, i.e., fingernail biting, cheek biting
- ☐ Mitral Valve Prolapse
- ☐ Cigarettes, pipe or cigar smoking
- ☐ Difficulty in opening mouth
- ☐ Accident to head, face or teeth
- ☐ Dental Floss
- ☐ Interdental stimulators / brushes
- ☐ Water jet device
- ☐ TMJ treatment
- ☐ Clicking sounds in jaw joint
- ☐ Backaches or neckaches

MEDICAL HISTORY

PHYSICIAN'S NAME ______ TOWN______ TELEPHONE NO.______ DATE OF LAST MEDICAL EXAM.______

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Allergy to penicillin
- ☐ Allergies to other drugs ______
- ☐ Allergies to anesthetics or novacaine
- ☐ Any heart ailments or heart murmur
- ☐ High blood pressure
- ☐ Neurological problems
- ☐ Radiation treatments
- ☐ Excessive bleeding from cut or extraction
- ☐ Anemia or blood problems
- ☐ HIV positive
- ☐ Hormonal or menstrual problems
- ☐ Asthma
- ☐ Hay fever or allergies in general
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Liver problems or hepatitis
- ☐ Malignancies
- ☐ Psychiatric care/emotional problems
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Hospitalized or serious illness in last 5 years For:
- ☐ Stroke
- ☐ Thyroid
- ☐ Eye disorders
- ☐ Fainting spells or seizures
- ☐ Tuberculosis
- ☐ Ulcer or colitis
- ☐ Pregnant, what month ______
- ☐ Arthritis
- ☐ Venereal disease
- ☐ Artificial joints or prostheses

☐ Are you taking any medications now? If so, what? ______

For how long? ______

Describe any medical treatment including drugs taken, if not listed above ______

______

______

SIGNATURE ______ DATE ______

REVIEWED BY ______ UPDATES: