

PATIENT INFORMATION SHEET

Version 2/08

Patient's Name _____ Preferred _____ Date _____

Soc Sec # _____ Sex _____ Birthdate _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Contacts: Please circle preferred method of contact and specify best time to call

Home Phone _____ Business _____ Cellular _____

Email _____ Referred By _____

Who will pay for this account _____ Relationship _____

3rd PARTY REIMBURSEMENT- We would like you to know that we do not participate with any dental insurance plan and you are expected to pay for your treatment at the time of service. We will, as a courtesy, file your claim electronically for your direct reimbursement. If we encounter problems with filing, we will ask you to contact your insurance company directly.

Who's name is the reimbursement plan under? (ie. yours, your spouse's or a parent) _____

Your Employer _____

Address _____ City _____ State _____ Zip _____

Primary Insurance Carrier _____ Group # _____

Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Soc Sec # _____ Sex _____ Birthdate _____

Spouse's Employer _____

Secondary Insurance Carrier _____ Group # _____

Address _____ City _____ State _____ Zip _____

Is there anything else we should know about you _____

MEDICAL HEALTH HISTORY

The following information is essential for us to provide you with safe and effective dental care that is compatible with your health. To receive treatment in our office, all questions must be answered on this history form. Please use a blue or black pen. If a question is not understood or you are not sure how to answer it, please discuss it with the clinician. Some questions may not relate to your condition; in that event, please write N/A (not applicable). For other responses, please write YES or NO. Please elaborate if your answer is YES. To properly evaluate your current health status it may be necessary for us to contact your physician.

Please find attached our Privacy Policy Declaration which follows the Health Insurance Portability and Accountability Act (HIPAA) guidelines. It explains our safeguards to protect your confidentiality regarding any information gained from this history or during the subsequent interview and information received from other health care practitioners.

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In the event of an emergency, who should we contact _____ Phone _____

1- Physician's name _____ Phone _____

Address _____ City _____ State _____ Zip _____

2- Date of last visit _____ Reason _____

3- Please list any medications and/or supplements you are taking. *There are many drug and medication incompatibilities, some of which may result in dangerous health problems. This information about your current use of drugs and medications is essential.*

Name _____ Dose _____ Why _____

Name _____ Dose _____ Why _____

Name _____ Dose _____ Why _____

Name _____ Dose _____ Why _____

Name _____ Dose _____ Why _____

Name _____ Dose _____ Why _____

Name _____ Dose _____ Why _____

Have you had or do you have any of the following:

4- An allergic reaction to a medication (hives, itching, difficulty, breathing)? _____ If so, please describe

5- An adverse reaction to a medication (nausea, vomiting, other non-life-threatening reactions)? _____ If so, please describe _____

6- A need to premedicate prior to dental work? Some conditions that require this are: Rheumatic heart disease/fever; congenital heart disease/murmur; prosthetic joints, pins, plates or screws; haven taken Phen-Fen.

Write in which _____

7- If you have premedicated, what regimen have you used in the past? _____

8- Do you suffer from any disability? _____

9- Heart trouble: attack, surgery, pacemaker, angina or irregular beats? _____

10- Allergy to antibiotics, aspirin, local anesthetic or any medication? _____

11- Abnormal blood pressure, excessive bleeding or anemia? _____

12- Breathing challenges, asthma, tuberculosis, sinusitis, hay fever or any other inhalation allergies?

13- Liver diseases, hepatitis or jaundice _____

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14- Endocrine challenges such as diabetes or thyroid problems? _____

15- Gastric challenges, ulcers, stomach or intestinal problems? _____

16- Kidney disease or dialysis? _____

17- Nervous disorders, epilepsy, convulsions, strokes or fainting spells? _____

18- Drug dependency on alcohol, analgesics or other? _____

19- Have you ever, or are you now using illegal drugs? _____ If yes, what drugs, and when taken?

There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and could be fatal.

20- Joint challenges such as arthritis or rheumatism? _____

21- Cancer, tumors, growths and their treatments (surgery, radiation or chemotherapy)? _____

22- Venereal diseases or herpes? _____

23- HIV+, ARC or AIDS? _____ If yes, describe and provide current status _____

24- Do you smoke? _____ How much and for how long? _____ Snuff/chew? _____

25- Have you seen a psychiatrist, psychologist or counselor? _____

26- Had an injury to your head or neck? Describe _____

27- Are you on any special diet? _____ What kind? _____

28- Women, are you pregnant? _____ If yes, when are you due? _____

29- Women, are you using birth control pills? _____ *There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.*

30- Are you on have you ever taken Fosamax or any osteoporosis/osteopenia medication? _____

31- Have you been hospitalized or had a major operation? _____

32- Are there any other health challenges we should know about? _____

DENTAL HEALTH HISTORY

Date of last visit _____ Reason _____

Your reason for seeing us today _____

Where may we request your dental records and radiographs?

Previous dentist's name _____ Address _____

City _____ State _____ Phone _____

Patient's Name _____

Have you had or do you have any of the following:

- 33- Local anesthetic (ie. Novocaine)? _____ Any adverse reactions? _____
- 34- Nitrous Oxide (a.k.a. "laughing gas", "sweet air")? _____ Any adverse reactions? _____
- 35- Have you ever fainted or had an adverse or allergic reaction to any treatment? _____
- 36- Numbness or bleeding following treatment? _____
- 37- Do your gums bleed? _____ Have you had periodontal therapy in the past? _____
- 38- Any sensitivity or aching to hot/cold/sweets/pressure? _____ Looseness? _____
- 39- TMJ/TMD therapy or symptoms such as tooth movement, sore head & neck muscles or joints, noise when opening/closing or limitation in opening? _____
- 40- Do you brux (clench or grind) your teeth? _____
- 41- Does food catch between your teeth? _____ Where? _____
- 42- Growths or sores in your mouth? _____
- 43- Do you have any other concerns relating to your teeth or treatment? _____

ANY CHANGES TO THE ABOVE INFORMATION SHOULD BE REPORTED TO US AT THE EARLIEST POSSIBLE TIME.

To the best my knowledge, the foregoing questions have been accurately answered.

Print Name of person completing form: _____

Signature: _____ Date: _____

If other than patient, indicate relationship _____

Dentist's History Review and Significant Findings

Dental office staff who reviewed history _____

Signature: Dr. _____ Date: _____