

PATIENT INFORMATION

CONFIDENTIAL

(PLEASE PRINT)

PATIENT # _____

DATE _____

NAME _____ BIRTHDATE _____ HOME PHONE _____

FIRST MI LAST

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

E-MAIL _____ CELL PHONE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE/PROV. _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ FINANCIAL INSTITUTION _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

X

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

SIGNATURE

Patterson #053-0246

PATIENT NAME _____
 HOME ADDRESS _____

 E-MAIL _____
 BUSINESS ADDRESS _____

TODAY'S DATE _____
 DATE OF BIRTH _____
 HOME PHONE _____
 CELL PHONE _____
 BUSINESS PHONE _____
 SS #/SIN _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

YES NO

1. ARE YOU UNDER MEDICAL TREATMENT NOW? ☐ ☐

2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? ☐ ☐

3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? ☐ ☐

IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____

4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX? ☐ ☐

5. DO YOU USE TOBACCO? ☐ ☐

6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS? ☐ ☐

7. ARE YOU WEARING CONTACT LENSES? ☐ ☐

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

YES NO YES NO YES NO

☐ ☐ LOCAL ANESTHETICS (E.G. NOVOCAINE) ☐ ☐ BARBITURATES ☐ ☐ ASPIRIN

☐ ☐ PENICILLIN OR OTHER ANTIBIOTICS ☐ ☐ SEDATIVES ☐ ☐ OTHER _____

☐ ☐ SULFA DRUGS ☐ ☐ IODINE _____

9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)? ☐ ☐

10. WOMEN ONLY:

A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? ☐ ☐

B) ARE YOU NURSING? ☐ ☐

C) ARE YOU TAKING BIRTH CONTROL PILLS? ☐ ☐

11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES NO	YES NO	YES NO
☐ ☐ HIGH BLOOD PRESSURE	☐ ☐ HEART DISEASE	☐ ☐ CHEST PAINS
☐ ☐ HEART ATTACK	☐ ☐ CARDIAC PACEMAKER	☐ ☐ EASILY WINDED
☐ ☐ RHEUMATIC FEVER	☐ ☐ HEART MURMUR	☐ ☐ STROKE
☐ ☐ SWOLLEN ANKLES	☐ ☐ ANGINA	☐ ☐ HAY FEVER / ALLERGIES
☐ ☐ FAINTING / SEIZURES	☐ ☐ FREQUENTLY TIRED	☐ ☐ TUBERCULOSIS
☐ ☐ ASTHMA	☐ ☐ ANEMIA	☐ ☐ RADIATION THERAPY
☐ ☐ LOW BLOOD PRESSURE	☐ ☐ EMPHYSEMA	☐ ☐ GLAUCOMA
☐ ☐ EPILEPSY / CONVULSIONS	☐ ☐ CANCER	☐ ☐ RECENT WEIGHT LOSS
☐ ☐ LEUKEMIA	☐ ☐ ARTHRITIS	☐ ☐ LIVER DISEASE
☐ ☐ DIABETES	☐ ☐ JOINT REPLACEMENT OR IMPLANT	☐ ☐ HEART TROUBLE
☐ ☐ KIDNEY DISEASES	☐ ☐ HEPATITIS / JAUNDICE	☐ ☐ RESPIRATORY PROBLEMS
☐ ☐ AIDS OR HIV INFECTION	☐ ☐ SEXUALLY TRANSMITTED DISEASE	☐ ☐ OTHER _____
☐ ☐ THYROID PROBLEM	☐ ☐ STOMACH TROUBLES / ULCERS	

COMMENTS

SIGNATURE OF DENTIST

DATE

PATIENT DENTAL HISTORY

	YES	NO		YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐	8. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	☐	9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	☐	☐	10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐	11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐	12. HAVE YOU HAD ANY ORTHODONTIC WORK?	☐	☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐	☐	13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?			14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	☐	☐
A) CLICKING?	☐	☐	15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	☐	☐
B) PAIN (JOINT, EAR, SIDE OF FACE)?	☐	☐			
C) DIFFICULTY IN OPENING OR CLOSING?	☐	☐			
D) DIFFICULTY IN CHEWING?	☐	☐			

SIGNATURE

X

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

PATIENT, PARENT OR GUARDIAN

DATE