

Patient Information Form

Name

Address

City

State

Zip

Home Phone #

Work #

Cell #

DOB

Gender

Medical History

Date of Last Visit

Please list all medications you are currently taking:

Allergies

(Women) Are you pregnant? Yes No

Taking birth control pills? Yes No

Do you have any of the following?

- | | | |
|--------------------------------------------------|-----------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> CANCER | <input type="checkbox"/> JAW PAIN |
| <input type="checkbox"/> CORTISONE TREATMENTS | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> SKIN RASH |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> CHEMICAL DEPENDENCY | <input type="checkbox"/> KIDNEY DISEASE |
| <input type="checkbox"/> COUGH, PERSISTENT | <input type="checkbox"/> HEART PROBLEMS | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> ARTHRITIS, RHEUMATISM | <input type="checkbox"/> CHEMOTHERAPY | <input type="checkbox"/> LIVER DISEASE |
| <input type="checkbox"/> COUGH UP BLOOD | | <input type="checkbox"/> SWELLING OF FEET OR ANKLES |
| <input type="checkbox"/> ARTIFICIAL HEART VALVES | <i>(describe)</i> | <input type="checkbox"/> MITRAL VALVE PROLAPSE |
| <input type="checkbox"/> DIABETES | | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> ARTIFICIAL JOINTS | <input type="checkbox"/> CIRCULATORY PROBLEMS | <input type="checkbox"/> NERVOUS PROBLEMS |
| <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> HEMOPHILIA | <input type="checkbox"/> TOBACCO HABIT |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> PACEMAKER |
| <input type="checkbox"/> FAINTING | <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> TONSILLITIS |
| <input type="checkbox"/> BACK PROBLEMS | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> PSYCHIATRIC CARE |
| <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> SCARLET FEVER | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> BLOOD DISEASE | <input type="checkbox"/> HIV POSITIVE | <input type="checkbox"/> RADIATION TREATMENT |
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> ULCER |

Dental History

Former Dentist

Reason for today's visit

Date of last exam

Date of last X-rays

How often do you brush?

How often do you floss?

Please check any of the following conditions that apply:

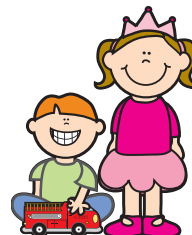
- | | |
|---------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> BAD BREATH | <input type="checkbox"/> PERIODONTAL TREATMENT |
| <input type="checkbox"/> BLEEDING GUMS | <input type="checkbox"/> SENSITIVITY TO COLD |
| <input type="checkbox"/> CLICKING OR POPPING JAW | <input type="checkbox"/> SENSITIVITY TO HOT |
| <input type="checkbox"/> FOOD COLLECTION BETWEEN TEETH | <input type="checkbox"/> SENSITIVITY TO SWEETS |
| <input type="checkbox"/> GRINDING TEETH | <input type="checkbox"/> SENSITIVITY WHEN BITING |
| <input type="checkbox"/> LOOSE TEETH OR BROKEN FILLINGS | <input type="checkbox"/> SORES OR GROWTHS IN YOUR MOUTH |

Authorization

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. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYERS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS

Signature

where **tLc+fun** = awesome smiles!



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