PATIENT INFORMATION FORM

Today's Date _____

NAME _____ HM # _____ WK # _____ CELL _____

HOME ADDRESS _____ CITY _____ ZIP CODE _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____ AGE _____

PLACE OF EMPLOYMENT _____ OCCUPATION _____

SPOUSE/PARENT NAME _____ WORK PHONE _____

SPOUSE/PARENT PLACE OF EMPLOYMENT _____ SS # _____

NEAREST RELATIVE NOT LIVING WITH YOU _____ PHONE _____

NEAREST FRIEND NOT LIVING WITH YOU _____ PHONE _____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY? _____ PHONE _____

PHYSICIAN _____ PHONE _____

GENERAL DENTIST _____ PHONE _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT? _____

DO YOU HAVE DENTAL INSURANCE? Yes _____ No _____ MEDICAL INSURANCE? Yes _____ No _____

DENTAL HISTORY

Date of last dental cleaning and check-up _____

DO YOU:	**Yes**	**No**
Have pain in your mouth?		
Where? _____		
Have frequent headaches?		
Have popping or clicking joints in front of your ears?		
Have pain in the joints in front of your ears?		
Clench or grind your teeth? (circle which)		
Have frequent problems with bad breath?		

ALSO:

When were you first told of your periodontal (gum) problems? _____ _____

Use tobacco products: Which and how much? _____

Drink alcohol: How much? _____

HAVE YOU:	**Yes**	**No**
Had gum surgery?		
Had periodontal scaling? (deep cleaning)		
Noticed bleeding gums when you brush?		
Had any teeth shift recently?		
Had orthodontics (braces)?		
Ever had a serious injury or blow to your mouth?		
Had your wisdom teeth removed?		
If yes, when? _____		

DENTAL CARE:

How often do you brush? _____

How often do you floss? _____

Which kind of toothbrush do you use? _____

List any other oral hygiene products you use: _____

_____

How often do you have dental cleanings and check-ups? _____

(Continued on back of page)

Do not write in this area

_____

MEDICAL HISTORY

Date of last complete physical exam _____ Height _____ Weight _____

DO YOU HAVE, HAVE YOU HAD, ARE YOU:	Yes	No
Hepatitis or liver disease		
Epilepsy, convulsions, or seizures		
Rheumatic fever		
Kidney or bladder disease		
Diabetes		
Tuberculosis or emphysema		
Heart attack		
Heart trouble		
Heart murmur		
Stroke		
High/low blood pressure (circle which)		
Shortness of breath/swollen ankles		
Chest pains (angina)		
Allergies		
Cancer		
Chemotherapy/radiation therapy		
Hospitalization for illness or injury		
Surgery		
Glaucoma		
Hemophilia		
Arthritis		
Lupus		
Psychiatric treatment		
Thyroid trouble		
Stomach ulcers		
Sinus problems		
Asthma		
Anemia		
Heart valve replacement		
Hip or knee replacement (circle which)		
Other prosthetic device		
HIV positive		
AIDS		

Any serious illness not listed? _____

IF FEMALE, ARE YOU NOW:	Yes	No
Pregnant		
Taking birth control pills		
Through menopause		

DO YOU HAVE/HAVE YOU HAD AN UNFAVORABLE REACTION TO:

Aspirin		
Barbiturates		
Scopolamine		
General anesthetics		
Local (dental) anesthetics		
Penicillin or amoxicillin		
Erythromycin		
Tetracycline or doxycycline		
Other antibiotics		
Codeine		
Demerol		
Vicodin		
Other pain medications		
Any other drugs		

Which? _____

ARE YOU:

Presently under a physician's care		
Taking any medications now		
Or within the past year		
Such as: Antibiotics		
Anticoagulants (blood thinners)		
Antidepressants		
Aspirin		
Blood pressure medication		
Cortisone/other steroid		
Diabetes tablets		
Hormone medication		
Insulin		
Thyroid tablets		
Subject to frequent urination		
Often thirsty		
Subject to prolonged bleeding after injury or tooth extraction		
Have you ever taken prescription diet pills (e.g. Fen-Phen, Redux, Pondimin)		

Please add anything you feel is important _____

List all medications you now take, including vitamins and homeopathic medications _____

Patient's or parent's signature _____

Do not write in this area Dr: _____ ASA Category: _____ BP: _____ / _____ P: _____ R: _____