

**PLEASE PRINT
CONFIDENTIAL PATIENT RECORD**

DATE: _____

*Your cooperation in filling the data on this confidential questionnaire is essential in aiding us to perform the highest standard of dental care. All information is strictly confidential and will remain with this office.

ACCT # _____

PATIENT NAME		DATE OF BIRTH		/	/	/
HOME ADDRESS		CITY	STATE	ZIP		
HOME PHONE		BUSINESS PHONE				
EMERGENCY NO:		EMPLOYER				
SOC. SEC. NO:	/	/	MARITAL STATUS	SINGLE	MARRIED	
PARENT OR GUARDIAN		SOC. SEC. NO:	/	/	/	

DENTAL INSURANCE: YES / NO **DRIVERS LICENSE #** _____ **STATE:** _____

Referred by: TV TV-Guide Newspaper Yellow Pages Patient Other _____

MEDICAL HISTORY

What drugs are you allergic to: _____

Do you have or have you had any of the following?

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Angina
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis: Type: _____
<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease			

What drugs are you currently taking? _____

WOMEN:

Are you taking birth control meds? _____
 Are you pregnant? _____
 If Yes, How Long? _____
 Names of Ob/Gyn: _____
 Tel # _____

OFFICE USE ONLY

Medical History Update			
Date	Normal	Change	Int.
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Physician's Name _____
 Phone Number _____

Have you been hospitalized in the last 5 years? If YES, Why? _____

DENTAL HISTORY

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Are you having any discomfort at this time? Please specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you been under regular care by a dentist? How long since your last dental visit? _____ What was done at that time? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do your gums feel tender or swollen?
<input type="checkbox"/>	<input type="checkbox"/>	Are you aware of any lump or swelling in your mouth?
<input type="checkbox"/>	<input type="checkbox"/>	Are you anxious to keep your natural teeth?
<input type="checkbox"/>	<input type="checkbox"/>	Would you like whiter teeth?
<input type="checkbox"/>	<input type="checkbox"/>	Describe in your own words what you would like done with your teeth: _____

DO YOU CURRENTLY EXPERIENCE?

<input type="checkbox"/> loose teeth	<input type="checkbox"/> missing teeth
<input type="checkbox"/> sensitive teeth	<input type="checkbox"/> gagging
<input type="checkbox"/> ear ache	<input type="checkbox"/> unsatisfactory dentures
<input type="checkbox"/> headache	<input type="checkbox"/> pops / clicks in jaw joints
<input type="checkbox"/> sore gums	<input type="checkbox"/> spaced or crooked teeth
<input type="checkbox"/> bleeding gums	<input type="checkbox"/> bad breath

IF YOU ARE WEARING DENTURES OR PARTIALS:
 a. How old are they? _____ years
 b. Do you use denture adhesive? YES NO

CONSENT: I understand the use of anesthetic agents embodies a certain risk. I also 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 detrimental to my health. Some Dentists who practice at this office are independent contractors who exercise independent professional judgment in treating their patients. They are not employed, supervised, or controlled by this office. The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed necessary by Doctor to make a thorough diagnosis of the patient's dental needs. To avoid misunderstanding regarding dental insurance, we wish our patients to know that most policies do not cover 100% of dental fees. Costs not covered by insurance will be the responsibility of the above patient. Payment is due immediately upon services rendered unless other formal arrangements have been made.

SIGNATURE: I certify that I have read and understand the above Consent Information.

 Patient, Parent, or Guardian

 Date