



Date: _____

PLEASE PRINT IN INK

PATIENT INFORMATION

Form for Patient Information including fields for First Name, M.I., Last Name, Nickname, SS No., Sex, Date of Birth, Age, Address, City, State, Zip, Home Phone, Cell Phone, Email, School, Grade, Hobbies, Occupation, Employer, Whom may we thank for recommending us?, Dentist, Date of last visit, Related patients, and Names and ages of other children.

PARENT INFORMATION (Please complete if patient is a minor)

Form for Parent Information with two columns for Father's and Mother's details, including Name, SS No., DOB, Address, City, State, Zip, H Phone, WK Phone, C Phone, FAX, and Email.

INSURANCE AND RESPONSIBLE PARTY

Form for Insurance and Responsible Party including questions about dental insurance, policy holder, insurance company, responsible party, and contact information for the responsible party.

MEDICAL HISTORY

IS THE PATIENT IN GOOD GENERAL HEALTH? YES NO

HAS THERE BEEN A CHANGE IN GENERAL HEALTH WITHIN THE LAST YEAR? YES NO

IS THE PATIENT CURRENTLY UNDER THE CARE OF A PHYSICIAN? YES NO

IF YES, WHAT IS BEING TREATED? _____

PHYSICIAN NAME _____

HAS PATIENT BEEN HOSPITALIZED IN THE LAST FIVE YEARS? YES NO

REASON FOR HOSPITALIZATION _____

DOES PATIENT CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS?

- | | | |
|---|---|---|
| <p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> BONE DISORDERS</p> <p><input type="checkbox"/> <input type="checkbox"/> HEART TROUBLE</p> <p><input type="checkbox"/> <input type="checkbox"/> MITRAL VALVE PROLAPSE</p> <p><input type="checkbox"/> <input type="checkbox"/> RHEUMATIC TROUBLE</p> <p><input type="checkbox"/> <input type="checkbox"/> THYROID PROBLEMS</p> <p><input type="checkbox"/> <input type="checkbox"/> DIABETES</p> <p><input type="checkbox"/> <input type="checkbox"/> EMOTIONAL PROBLEMS</p> <p><input type="checkbox"/> <input type="checkbox"/> BRAIN INJURY</p> | <p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> KIDNEY OR LIVER INVOLVEMENT</p> <p><input type="checkbox"/> <input type="checkbox"/> JOINT PROSTHESIS</p> <p><input type="checkbox"/> <input type="checkbox"/> TUBERCULOSIS</p> <p><input type="checkbox"/> <input type="checkbox"/> ANEMIA</p> <p><input type="checkbox"/> <input type="checkbox"/> EPILEPSY</p> <p><input type="checkbox"/> <input type="checkbox"/> PROLONGED BLEEDING</p> <p><input type="checkbox"/> <input type="checkbox"/> FAINTNESS/DIZZINESS</p> <p><input type="checkbox"/> <input type="checkbox"/> ADOPTED</p> | <p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> TONSILS REMOVED</p> <p><input type="checkbox"/> <input type="checkbox"/> ADENOIDS REMOVED</p> <p><input type="checkbox"/> <input type="checkbox"/> EARACHES</p> <p><input type="checkbox"/> <input type="checkbox"/> ARTHRITIS</p> <p><input type="checkbox"/> <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE</p> <p><input type="checkbox"/> <input type="checkbox"/> AIDS OR HIV</p> <p><input type="checkbox"/> <input type="checkbox"/> FEMALES - ARE YOU PREGNANT?</p> <p><input type="checkbox"/> <input type="checkbox"/> FEMALES - HAS MENSTRUATION BEGUN?</p> |
|---|---|---|

HAS PATIENT EVER TAKEN BISPHOSPHONATES OR OTHER BONE MEDICATIONS? YES NO

LIST ANY OTHER SERIOUS ILLNESS _____

LIST ANY ALLERGIES _____

LIST ALL DRUGS AND MEDICATIONS CURRENTLY BEING TAKEN _____

DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE THAT YOU THINK WE SHOULD KNOW ABOUT? IF SO, PLEASE EXPLAIN:

DENTAL HISTORY

PLEASE CHECK YES OR NO:

- | | | |
|--|--|---|
| <p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> INJURIES TO FACE, MOUTH, TEETH?</p> <p><input type="checkbox"/> <input type="checkbox"/> THUMB, FINGER, LIP SUCKING HABIT?</p> <p><input type="checkbox"/> <input type="checkbox"/> MORE THAN AVERAGE AMOUNT OF DECAY?</p> <p><input type="checkbox"/> <input type="checkbox"/> ANY MISSING PERMANENT TEETH?</p> <p><input type="checkbox"/> <input type="checkbox"/> EXTRA PERMANENT TEETH?</p> <p><input type="checkbox"/> <input type="checkbox"/> TEETH REMOVED BY EXTRACTION?</p> <p><input type="checkbox"/> <input type="checkbox"/> DIFFICULTY IN SWALLOWING OR CHEWING?</p> | <p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> BLEEDING OF GUMS/ BAD TASTE IN MOUTH?</p> <p><input type="checkbox"/> <input type="checkbox"/> TEETH SENSITIVE TO HOT/COLD?</p> <p><input type="checkbox"/> <input type="checkbox"/> PERIODONTAL PROBLEMS?</p> <p><input type="checkbox"/> <input type="checkbox"/> FREQUENT ULCERS/CANKER SORES?</p> <p><input type="checkbox"/> <input type="checkbox"/> ABNORMAL SWALLOWING/TONGUE THRUST?</p> <p><input type="checkbox"/> <input type="checkbox"/> MOUTH BREATHING HABIT?</p> <p><input type="checkbox"/> <input type="checkbox"/> NEGATIVE DENTAL EXPERIENCE?</p> | <p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> HISTORY OF TMJ DISORDER?</p> <p><input type="checkbox"/> <input type="checkbox"/> PAIN IN THE JAW JOINT?</p> <p><input type="checkbox"/> <input type="checkbox"/> PAIN IN THE MUSCLES OF THE FACE?</p> <p><input type="checkbox"/> <input type="checkbox"/> CLICKING/POPPING/LOCKING OF JAW JOINT?</p> <p><input type="checkbox"/> <input type="checkbox"/> BEEN TREATED FOR "TMJ"?</p> <p><input type="checkbox"/> <input type="checkbox"/> BITE FEEL UNCOMFORTABLE?</p> <p><input type="checkbox"/> <input type="checkbox"/> GRINDING/CLENCHING OF TEETH?</p> |
|--|--|---|

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? YES NO

REASON _____

WHAT WOULD YOU LIKE TREATMENT TO ACCOMPLISH? _____

COMMENTS _____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE. I ACKNOWLEDGE THAT I HAVE COMPLETED THE FORM TO THE BEST OF MY KNOWLEDGE, AND THAT MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I WILL NOT HOLD MY DENTIST OR ANY MEMBER OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE. IF THERE ARE ANY FUTURE CHANGES TO THIS HISTORY RECORD, I WILL INFORM THE PRACTICE.

SIGNATURE: _____

DATE: _____