

PATIENT DENTAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

REASON FOR VISIT _____
 WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____
 HOW OFTEN DID YOU VISIT YOUR DENTIST BEFORE THEN? _____
 HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN, WHERE? _____
 PREVIOUS DENTIST (NAME AND LOCATION) _____
 HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN, WHERE? _____
 HOW OFTEN DO YOU BRUSH YOUR TEETH? _____ HOW OFTEN DO YOU FLOSS YOUR TEETH? _____
 IS YOUR DRINKING WATER FLUORIDATED? _____

DO YOU GYMS BLEED WHILE BRUSHING OR FLOSSING? Y N ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?..... Y N ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?..... Y N DO YOU HAVE ANY SORES OR BUMPS IN OR AROUND YOUR MOUTH?..... Y N HAVE YOU HAD ANY NECK OR JAW INJURIES?..... Y N HAVE YOU EVER EXPERIENCE ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW? CLICKING Y N PAIN (JOINT, EAR, SIDE OF FACE) Y N DIFFICULTY IN OPENING OR CLOSING Y N DIFFICULTY IN CHEWING Y N DO YOU HAVE FREQUENT HEADACHES?..... Y N DO YOU CLENCH OR GRIND YOUR TEETH? Y N DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? Y N	DO YOU FEEL ANY PAIN IN YOUR TEETH?..... Y N HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH?..... Y N DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH? Y N HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)?..... Y N EVER WORN A BITE PLATE OR OTHER APPLIANCE?..... Y N HAVE YOU HAD ANY DIFFICULT EXTRACTIONS IN THE PAST? Y N HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACGTIONS? Y N DO YOU WEAR DENTURES OR PARTIALS? Y N IF YES, DATE OF PLACEMENT: _____ HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS?..... Y N
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IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

WHAT CAN WE DO TO MAKE YOU SMILE? CHECK-OFF ALL THAT APPLY, AND WE'LL GET BACK TO YOU WITH MORE INFORMATION ABOUT YOUR INQUIRY):

- | | | |
|---|---|---|
| <input type="checkbox"/> INSTANT ORTHODONTICS | <input type="checkbox"/> VENEERS | <input type="checkbox"/> REPLACE MISSING TEETH |
| <input type="checkbox"/> GUMMY SMILE | <input type="checkbox"/> NEUROMUSCULAR DENTISTRY | <input type="checkbox"/> REPAIR BROKEN OR CRACKED TEETH |
| <input type="checkbox"/> ONE HOUR IN-OFFICE WHITENING | <input type="checkbox"/> WHITE FILLINGS | <input type="checkbox"/> CORRECT MISALIGNED TEETH |
| <input type="checkbox"/> DENTAL ANXIETY | <input type="checkbox"/> REPLACING METAL FILLINGS | <input type="checkbox"/> REJUVENATE WORN OR STAINED TEETH |
| <input type="checkbox"/> INVISALIGN TEETH STRAIGHTENING | <input type="checkbox"/> ELIMINATE GAPS | <input type="checkbox"/> DENTAL IMPLANTS |
| <input type="checkbox"/> TOTAL SMILE MAKEOVER | <input type="checkbox"/> WHITE FILLINGS | <input type="checkbox"/> HEADACHES/MIGRAINE RELIEF |

AUTHORIZATION AND RELEASE

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 RECORD OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO A THIRD PARTY PAYORS AND/OR OTHER HEALTH CARE PRACTITIONERS. 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 OF MY DEPENDENTS.

SIGNATURE _____ DATE _____

DOCTOR'S NOTES _____

SIGNATURE _____ DATE _____

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
ADDRESS _____
HOME PHONE _____ E-MAIL _____ DRIVER'S LIC. # _____
WORK PHONE _____ EMPLOYER _____ S.I.N. _____
DATE OF BIRTH _____ AGE: _____ SEX: _____ MARITAL STATUS _____
SPOUSE OR PARENT'S NAME _____ EMPLOYER _____
PERSON TO CONTACT IN CASE OF EMERGENCY _____ PHONE _____
IF STUDENT, NAME OF SCHOOL _____ GRADE _____
WHOM MAY WE THANK FOR REFERRING YOU _____

RESPONSIBLE PARTY (PLEASE COMPLETE ALL INFORMATION IF DIFFERENT THAN ABOVE)

NAME _____ RELATIONSHIP TO PATIENT _____
ADDRESS _____ HOME PHONE _____
DRIVER'S LICENSE # _____ DATE OF BIRTH _____ S.I.N. _____
EMPLOYER _____ WORK PHONE _____
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED _____ DATE OF BIRTH _____
EMPLOYER/GROUP POLICY HOLDER _____ INSURANCE YEAR END _____
INSURANCE COMPANY _____ PHONE _____
GROUP/INDIVIDUAL POLICY # _____ CERTIFICATE # _____
I.D./S.I.N. _____ MAXIMUM COVERAGE _____ % USED _____
PERCENTAGE COVERAGE BASIC _____ MAJ. REST. _____ ORTHO _____

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

NAME OF INSURED _____ DATE OF BIRTH _____
EMPLOYER/GROUP POLICY HOLDER _____ INSURANCE YEAR END _____
INSURANCE COMPANY _____ PHONE _____
GROUP/INDIVIDUAL POLICY # _____ CERTIFICATE # _____
I.D./S.I.N. _____ MAXIMUM COVERAGE _____ % USED _____
PERCENTAGE COVERAGE BASIC _____ MAJ. REST. _____ ORTHO _____

ITEM 27113 PATTERSON SOLUTIONS 1-800-487-0131

X
SIGNATURE OF PATIENT OR PARENT IF MINOR

PATIENT NUMBER

PATIENT MEDICAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO		YES	NO
1. ARE YOU IN GOOD HEALTH	<input type="checkbox"/>	<input type="checkbox"/>	9. DO YOU BRUISE EASILY	<input type="checkbox"/>	<input type="checkbox"/>
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	<input type="checkbox"/>	<input type="checkbox"/>	10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	<input type="checkbox"/>	<input type="checkbox"/>
3. DATE OF YOUR LAST PHYSICAL EXAM: _____			11. HAVE YOU HAD A RECENT WEIGHT LOSS	<input type="checkbox"/>	<input type="checkbox"/>
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____			12. HAVE YOU EVER TAKEN FEN-PHEN OR REDUX ...	<input type="checkbox"/>	<input type="checkbox"/>
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN	<input type="checkbox"/>	<input type="checkbox"/>	13. DO YOU USE TOBACCO	<input type="checkbox"/>	<input type="checkbox"/>
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS PLEASE EXPLAIN. _____	<input type="checkbox"/>	<input type="checkbox"/>	14. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES	<input type="checkbox"/>	<input type="checkbox"/>
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____	<input type="checkbox"/>	<input type="checkbox"/>	15. ARE YOU WEARING CONTACT LENSES	<input type="checkbox"/>	<input type="checkbox"/>
8. HAVE YOU HAD ANY ABNORMAL BLEEDING.	<input type="checkbox"/>	<input type="checkbox"/>	16. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT	<input type="checkbox"/>	<input type="checkbox"/>

WOMEN ONLY:

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT

ARE YOU NURSING

ARE YOU TAKING BIRTH CONTROL PILLS

	YES	NO		YES	NO
ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:			HIVES OR SKIN RASH	<input type="checkbox"/>	<input type="checkbox"/>
LOCAL ANESTHETICS LIKE NOVOCAINE	<input type="checkbox"/>	<input type="checkbox"/>	FADING OR DIZZY SPELLS	<input type="checkbox"/>	<input type="checkbox"/>
PENICILLIN OR OTHER ANTIBIOTICS	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
SULFA DRUGS	<input type="checkbox"/>	<input type="checkbox"/>	AIDS OR HIV INFECTION	<input type="checkbox"/>	<input type="checkbox"/>
BARBITURATES, SEDATIVES OR SLEEPING PILLS ..	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
ASPIRIN	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>
IODINE	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS OR RHEUMATISM	<input type="checkbox"/>	<input type="checkbox"/>
ANY METALS (E.G., NICKEL, MERCURY, ETC.)	<input type="checkbox"/>	<input type="checkbox"/>	JOINT REPLACEMENT OR IMPLANT	<input type="checkbox"/>	<input type="checkbox"/>
LATEX / RUBBER	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER	<input type="checkbox"/>	<input type="checkbox"/>
OTHER (PLEASE LIST) _____			KIDNEY TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:			TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	PERSISTENT COUGH	<input type="checkbox"/>	<input type="checkbox"/>
SCARLET FEVER	<input type="checkbox"/>	<input type="checkbox"/>	COUGH THAT PRODUCES BLOOD	<input type="checkbox"/>	<input type="checkbox"/>
HEART DEFECT OR HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY (CANCER, LEUKEMIA)	<input type="checkbox"/>	<input type="checkbox"/>
HEART TROUBLE, HEART ATTACK, OR ANGINA ...	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>
SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>
PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>
HEART SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUSNESS	<input type="checkbox"/>	<input type="checkbox"/>
HIGH/LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	TONSILLITIS	<input type="checkbox"/>	<input type="checkbox"/>
CONGENITAL HEART PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	TUMORS	<input type="checkbox"/>	<input type="checkbox"/>
SWELLING OF FEET, ANKLES, HANDS	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL HEALTH CARE	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS, JAUNDICE OR LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	BACK PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	CHEMICAL DEPENDENCY	<input type="checkbox"/>	<input type="checkbox"/>
SINUS TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE	<input type="checkbox"/>	<input type="checkbox"/>
LUNG OR BREATHING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	CORTISONE TREATMENT	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA OR HAY FEVER	<input type="checkbox"/>	<input type="checkbox"/>	COLD SORES/FEVER BLISTERS	<input type="checkbox"/>	<input type="checkbox"/>
			HYPOGLYCEMIA	<input type="checkbox"/>	<input type="checkbox"/>
			EATING DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT NUMBER _____