Patient Information

Patient Name_____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ E-mail: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Have you ever had any of the following? Please check those that apply:

General

- ☐ Tire Easily
- ☐ Marked Weight Change
- ☐ Night Sweats

Nervous System

- ☐ Stroke
- ☐ Headache

Heart/ Blood Vessels

- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Chest Pain/ Discomfort
- ☐ Heart Attack
- ☐ Shortness of breath
- ☐ Swelling of ankles

Blood

- ☐ Bruise easily
- ☐ Anemia
- ☐ Blood transfusion
- ☐ HIV/ AIDS

Dental History

Mouth:

- ☐ Bleeding/ Sore Gums
- ☐ Burning Tongue/ Lips
- ☐ Frequent Blisters

Autoimmune

Teeth:

- ☐ Loose Teeth

- ☐ Convulsions/ Epilepsy
- ☐ Numbness/ Tingling
- ☐ Dizziness/ Fainting
- ☐ Psychiatric Treatment
- ☐ Tuberculosis

- ☐ High Blood Pressure

  Last Reading BP:_____
- ☐ Congenital Heart Disease
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve
- ☐ Heart Surgery

- ☐ Arthritis/ Rheumatism
- ☐ Lupus
- ☐ Any Other Autoimmune
- ☐ Cancer
- ☐ Pacemaker
- ☐ Radiation Therapy
- ☐ Chemotherapy

- ☐ Sensitive to hot/ cold/ sweet
- ☐ Sensitive to Biting
- ☐ Food impaction
- ☐ Clenching
- ☐ Shifting of teeth
- ☐ Bite changing

Respiratory

- ☐ Emphysema
- ☐ Asthma
- ☐ Persistent Cough
- ☐ Difficulty Breathing

- ☐ Other Heart Conditions
- ☐ Kidney Disease
- ☐ Increase frequency of urination (night)

Urinary

- ☐ Chronic Sinus Problems
- ☐ Prior use of diet drugs
- ☐ Other Relevant information

- ☐ Hip/ Knee Replacement
- ☐ Pain
- ☐ Clicking or popping
- ☐ Difficulty opening or closing jaw

- ☐ TMJ:

• Have you been admitted to a hospital or needed emergency care? ☐ Yes ☐ No
If yes, please explain: _____

• Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Are you currently taking any medications and for what? ☐ Yes ☐ No

Medication:	**Reason:**
_____	_____
_____	_____
_____	_____

• Are you taking any anticoagulants (blood thinners)? Are you taking aspirin on a regular basis? ☐ Yes ☐ No
• Are you ALLERGIC or have you ever experience any reaction to the following? ☐ Yes ☐ No

☐ Penicillin ☐ Latex ☐ Asprin

☐ Sulfa drugs ☐ Local Anesthetics ☐ Other Medications

• Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Spouse Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party or of payment/responsible party