PATIENT INFORMATION

Today's Date: ____/_____/_____

Patient Name: _____ Preferred Name: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #: _____ TDL#_____

Phone (Home) :_____(Work):_____EXT: _____ Cell_____

Birth Date _____ E-Mail Address: _____

Preferred Contact Method: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email ☐ Text

Preferred Appointment Confirmation Method: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email ☐ Text

Preferred Method to Schedule Appointments: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email ☐ Text

Home address: _____
Street City/State Zip Code

Work address: _____
Street City/State Zip Code

Employer Name: _____ Position: _____

Dental Insurance

Primary Insurance Information

Name: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

Insured SSN: _____ Insured DOB____/____/_____

Employer: _____ Insurance Name: _____

Address: _____ Member ID: _____

City, State, Zip: _____ Group Number: _____

Please list other members of your immediate family who are patients in our office

_____

Can we thank someone for referring you?

Family Member_____

Coworker_____

Friend _____

Doctor _____

Or did you find us on your own?

___Website
___Social Media
___Lumineer
___Insurance Company
___Walk in
___Post Card
___Other

What is the reason for your visit today? _____

_____

Date of Last Dental Visit: _____

Do you prefer Nitrous Oxide (laughing gas) during dental procedure? ☐ Yes ☐ No

Are you interested in whitening your teeth? ☐ Yes ☐ No

Are you interested in sedation dentistry? ☐ Yes ☐ No

Why did you leave your previous dentist? _____

If you could change your smile, what would you do? _____

Do you prefer to see a particular doctor in our practice? _____

DENTAL GROUP

HEALTH QUESTIONNAIRE

Today's Date _____ Patients Name _____ DOB_____

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality of care. <u>All information you provide will be kept confidential.</u>

***PLEASE ANSWER BY CIRCLING Yes (Y) or No (N) FOR EACH INDIVIDUAL QUESTION**

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year?.....Y N
3. Date of last check up by physician ____/____/____
4. Are you currently in a physician's care? .....Y N

If so, what for? _____

Treating Physician's Name: _____ Phone Number: _____

5. Have you had any serious illness, operations, or hospitalizations? .....Y N

If so, describe and give approximate dates: _____

_____

6. Have you ever had intravenous sedation or general anesthesia.....Y N
   Were there any adverse effects? .....Y N
7. Do you generally tolerate dental treatment well? .....Y N

<u>DO YOU HAVE OR HAVE YOU EVER HAD:</u>

- AIDS/HIV Positive Y N
- Alzheimer's Disease Y N
- Anaphylaxis Y N
- Anemia Y N
- Angina Y N
- Arthritis/Gout Y N
- Artificial Heart Valve Y N
- Artificial Joint Y N
- Asthma Y N
- Blood Disease Y N
- Blood Transfusion Y N
- Breathing Problems Y N
- Bruise Easily Y N
- Cancer Y N
- Chemotherapy Y N
- Chest Pain Y N
- Cold Sores/Fever Blisters Y N
- Congenital Heart Disorder Y N
- Convulsions Y N
- Cortisone Medicine Y N
- Diabetes Y N
- Drug Addiction Y N
- Easily Winded Y N
- Emphysema Y N
- Epilepsy or Seizures Y N
- Excessive Bleeding Y N
- Excessive Thirst Y N
- Fainting Spells/Dizziness Y N
- Frequent Cough Y N
- Frequent Diarrhea Y N
- Frequent Headaches Y N
- Genital Herpes Y N
- Glaucoma Y N
- Hay Fever Y N
- Heart Attack/Failure Y N
- Heart Murmur Y N
- Heart Pacemaker Y N
- Heart Trouble/Disease Y N
- Hemophilia Y N
- Hepatitis A Y N
- Hepatitis B or C Y N
- Herpes Y N
- High Blood Pressure Y N
- High Cholesterol Y N
- Hives or Rash Y N
- Hypoglycemia Y N
- Irregular Heartbeat Y N
- Kidney Problems Y N
- Leukemia Y N
- Liver Disease Y N
- Low Blood Pressure Y N
- Lung Disease Y N
- Mitral Valve Prolepses Y N
- Osteoporosis Y N
- Pain in Jaw Joints Y N
- Parathyroid Disease Y N
- Psychiatric Care Y N
- Radiation Treatment Y N
- Renal Dialysis Y N
- Rheumatic Fever Y N
- Shingles Y N
- Sickle Cell Disease Y N
- Sinus Trouble Y N
- Spinal Bifida Y N
- Stomach Disease Y N
- Stroke Y N
- Swelling of Limbs Y N
- Thyroid Disease Y N
- Tonsillitis Y N
- Tuberculosis Y N
- Tumors or Growths Y N
- Ulcers Y N
- Venereal Disease Y N
- Yellow Jaundice Y N

DENTAL GROUP

ARE, YOU ALLERGIC TO OR HAD A BAD REACTION FROM:

- Local anesthetics (Novocain-like drugs)? Y N
- Penicillin, Amoxicillin, Cephalosporins? Y N
- Other antibiotics? Y N
- Barbiturates, sedatives? Y N
- Aspirin, ibuprofen, or other pain medicines? Y N
- Codeine or other narcotics or opiods? Y N
- Latex? Y N
- Other allergies or reactions? Y N
  Please List: _____
- Do you smoke? Y N
  How Much? _____
- Do you use alcohol? Y N
  How Much? _____
- Do you use spit tobacco? Y N
  How Much? _____
- Metal? Y N
- Sulfa Drugs? Y N
- Acrylic? Y N

Do you have any other diseases, conditions or problems not listed above that you think the doctor should know about? _____

Any additional comments or concerns? _____

WOMEN ONLY: ☐ Pregnant ☐ Trying to get pregnant ☐ Breast Feeding ☐ Birth Control ☐ Taking hormonal replacement

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment, to the best of my knowledge; the information above is complete and accurate.

Date____/____/_____ Signature of person completing form_____