

PATIENT INFORMATION RECORD

Date: \_\_\_\_\_

GENERAL INFORMATION

Dr. Mr. Mrs. Ms. Name Last First Middle Date of Birth Social Security #
Residence Address City State Zip Residence Phone
Business Name & Address City State Zip Business Phone
Occupation Sex Height Weight Cell Phone / Pager
Spouse/Parents Name (if a minor) Who will be responsible for this account?

Who may we thank for the referral?

INSURANCE INFORMATION (Complete if Applicable)

Name and Address of Insurance Carrier:
Policy/Group Number: Employer:
Employee/Subscriber: Relationship to Patient:

MEDICAL HISTORY

General Health Excellent Good Fair Poor

Name and Address of Physician:

Last Complete Medical Exam:

Are you currently being treated by a physician? Yes No

For what?

Are you currently taking any medication? Yes No (Use back if needed)

Taking for Taking for

Taking for Taking for

Are you allergic to: Codeine Penicillin Local Anesthetic Other:

Do you have a medically diagnosed problem for prolonged bleeding? Yes No

Do you take blood thinners or anticoagulants? Yes No

Do you use any form of tobacco? Yes No

Do you drink alcohol weekly? Yes No

Do you feel you have a well balanced diet? Yes No

Why not?

How many times a day do you eat or drink something containing sugar? None 1 - 2 3 - 4 More

Have you ever been treated for or told you have:

Heart Disease Arthritis
Heart Murmur or Congenital Lesion Ulcers
Rheumatic Fever Epilepsy
Abnormal Blood Pressure Asthma or Hay Fever
(High/Low) Chronic Sinus Condition
Tuberculosis or Lung Disease Tumor or Cancer
Diabetes Stroke
Hepatitis or Jaundice Nervous Disorder
Venereal Disease Glaucoma
Anemia Other:

For Women:

Are you pregnant? Yes No Expected Delivery Date:

Do you take birth control pills? Yes No Hormones Yes No

**DENTAL HISTORY**

Reason for this visit: \_\_\_\_\_

Last Dental Visit: \_\_\_\_\_

Last Complete Dental Exam: \_\_\_\_\_ Last Full Mouth Xrays: \_\_\_\_\_

How often do you brush you teeth? \_\_\_\_\_ Floss? \_\_\_\_\_

What texture toothbrush do you use?       Soft               Medium               Hard               Nylon               Natural

Please check the appropriate box and give any details:

Yes     No    Are you presently in any dental pain? \_\_\_\_\_

Yes     No    Have you had an unfavorable dental experience in the past? \_\_\_\_\_

What would help you avoid this in the future? \_\_\_\_\_

Yes     No    Have you lost any teeth? From what cause? \_\_\_\_\_

Yes     No    Do you have any growths or swelling in your mouth? \_\_\_\_\_

How long? \_\_\_\_\_

Yes     No    Are your teeth sensitive?               Hot               Cold               Sweet               Pressure

Yes     No    Do you chew on only one side of your mouth?              Why? \_\_\_\_\_

Yes     No    Do your gums bleed?               When brushing?               When flossing?               At night?

Yes     No    Have you ever been told you have pyorrhea or periodontal (gum) disease?              When? \_\_\_\_\_

How were you treated? \_\_\_\_\_

Yes     No    Are you aware of grinding or clenching your teeth?               Awake               Asleep

Yes     No    Do your jaws ever feel tired?               Morning               During the day               Evening

Yes     No    Do you have tension headaches?              How often? \_\_\_\_\_

Yes     No    Have you ever been told you had problems with your bite or occlusal disease?              When? \_\_\_\_\_

How were you treated? \_\_\_\_\_

Yes     No    Do you wear Full or Partial Dentures?               Upper               Lowe

Check if you are unhappy with:               Fit               Appearance               Chewing efficiency

Yes     No    Do you usually have many cavities or break fillings easily?

Yes     No    Would you like to keep your natural teeth for the rest of your life?

Yes     No    Do you want to learn how to prevent dental diseases?

Yes     No    Are you deeply concerned about the financial investment to return your mouth to optimal health?

Please comment on anything you feel is important:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date

Signature (Parent or Guardian for a minor)

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