PATIENT DENTAL HISTORY

Patient's name_____ Date of Birth_____

Reason for this visit_____

Last dental visit (date) _____ Treatment provided at that time_____

Frequency of dental visits_____ Previous dentist (name and location) _____

Have you had a complete series of dental films/x-rays taken? _____ Where?_____

When? _____ Can we request these be sent to this office?_____

Please indicate Yes (Y) or No (N) to the following:

Do your gums bleed while brushing or flossing? ____

Are your teeth sensitive to hot or cold? ____

Are your teeth sensitive to sweets or sour? ____

Do you feel pain in any of your teeth? ____

Do you have any sores or lumps in or near your mouth? ____

Have you ever had any head, neck or jaw injuries? ____

Have you ever experienced any of the following problems in your jaw?

- Clicking ____
- Pain (joint, ear or side of face) ____
- Difficulty in opening/closing ____
- Difficulty in chewing ____

Do you have frequent headaches? ____

Do you clench or grind your teeth? ____

Do you bite your lips/cheeks frequently? ____

Have you notices any loosening of your teeth? ____

Does food get caught between your teeth? ____

Have you had periodontal (gum) treatment? ____

Have you received oral hygiene instruction for the care of your teeth and gums? ____

Have you difficult extractions before? ____

Have you had prolonged bleeding following extractions before? ____

Do you wear dentures or partials? ____

If yes, date of placement_____

Do you have dental implants? ____

If yes, date of placement_____

Have you had orthodontic treatment? ____

If yes, date of completing__ _____

Have you had treatment from a dental specialist? ____

If yes, what type?_____

Additional comments or concerns? _____

_____

_____

Dentist's comments_____

_____

_____

_____ _____ _____ _____

Patient's/Parent's/Guardian's signature | Date | Dentist's signature | Date

CONFIDENTIAL MEDICAL HISTORY Patient_____ Dr._____

Physician's name_____ Phone #_____

1. Are you in good health? Yes ____ No ____ If no, please provide details_____

   _____

2. When was the last time you had a medical examination?_____
3. Are you presently receiving treatment for any illness? If yes, please provide details:_____

   _____

4. Have you ever been hospitalized? If yes, please provide details_____

   _____

5. Do you have any heart or circulatory problems? Yes ____ No ____ Do you have a pacemaker? Yes ____ No ____
6. Have you ever had rheumatic fever? Yes ____ No ____ If yes, when_____
7. Have you ever been advised to take antibiotic pre-medication prior to dental treatment? Yes ____ No ____
8. Do you have allergies? Seasonal/hayfever ____ Food _____ Medication_____

   _____ Other_____
9. Are you presently taking any kind of medication? If yes, please specify:

   Drug _____ Reason _____

   Drug _____ Reason _____

   Drug _____ Reason _____
10. Have you ever had a reaction to any kind of medicine or dental local anaesthetic? If yes, please provide details:

    _____
11. Female patients – Are you pregnant or think you may be pregnant? Yes ___ No ___ Breastfeeding? Yes ___No ___
12. Please indicate below (√) if you **presently have** or **have ever had any** of the following:

❒ AIDS/HIV	❒ Diabetes	❒ Liver disease (Hepatitis/Jaundice)
❒ Alcohol or chemical dependency	❒ Eating disorders	❒ Lung disease/chest pains
❒ Arthritis or Rheumatism	❒ Epilepsy/seizures	❒Mental or nervous disorder
❒ Artificial joints or valves	❒ Fainting/dizzy spells	❒Stomach ulcers
❒ Asthma	❒ High/low blood pressure	❒Stroke
❒ Blood transfusion	❒ Hyper/hypo glycemia	❒Tuberculosis
❒ Cancer/radiotherapy/chemotherapy	❒ Kidney disease	❒Venereal/communicable disease

12. Do you smoke? If yes, how much per day?_____ per week? _____
13. Do you grind or clench your teeth? Yes ___ No ___
14. Do you suffer from headaches____ earaches_____ or neck aches_____?
15. Is there any additional information related to your health that has not been addressed above? _____

    _____

_____ _____ _____ _____

Patient or guardian's signature | Date | Reviewed by | Date

Medical history update:

_____ Date_____By_____

_____ Date_____By_____

_____ Date_____By_____

_____ Date_____By_____

CONFIDENTIAL PATIENT REGISTRATION **Dr.**_____

Welcome to our dental practice. Please complete the following important information.

Contact Information

Mr./Mrs./Ms/Miss/Dr. (please circle one)

Surname:_____ **First name:**_____ **Middle initial:**_____

Preferred name:_____ **Gender:** Female ___ Male ___ **Birthdate** M/D/Y: _____

Address:_____

Home phone:_____ **Cell phone:**_____ **Work phone:**_____

Preferred daytime contact number: (√) H___ C___ W___ **Email:**_____

Emergency contact: _____ **Relationship to patient:** _____

Daytime phone:_____ **Cell phone:**_____

Responsible Party – re treatment and financial considerations (Please complete all information if different from above)

Name:_____ **Relationship to patient:**_____

Address: _____

Home phone:_____ **Cell phone:**_____

Work phone:_____ **Preferred daytime contact number:** (√) H___ C___ W___

Email:_____

If the patient is a minor and a custody/guardianship order is in place, please provide details as to which person can provide authorization for dental care: _____

_____

Insurance Information

Policy holder:_____**Relationship to patient:**_____ **Birthdate** M/D/Y:_____

Employer:_____**Work phone:**_____ E**mail:**_____

Address: _____

Insurance company_____**Group/Policy #:**_____**Certificate/Div/ID #:**_____

Coverage: Basic:_____**% limit: $**_____ **Major:**_____**% limit: $**_____ **Ortho:**_____**% limit: $**_____

Secondary policy

Policy holder:_____**Relationship to patient:**_____ **Birthdate** M/D/Y:_____

Employer:_____**Work phone:**_____ E**mail:**_____

Address: _____

Insurance company_____**Group/Policy #:**_____**Certificate/Div/ID #:**_____

Coverage: Basic:_____**% limit: $**_____ **Major:**_____**% limit: $**_____ **Ortho:**_____**% limit: $**_____

Many dental insurance plans allow us to submit claims electronically on your behalf. In order to do this we require your authorization.

I authorize the release of information contained in claims submitted electronically to my dental benefits provider. I also authorize the communication of information related to dental coverage and benefits to my dental insurance provider. If allowed, I also assign my benefits payable from claims submitted electronically and authorize payment directly to this dental practice.

_____ _____

Signature of patient or parent/guardian of minor Date