Health and Dental History

Today's Date: _____
Name: _____ Date of Birth: _____
Nickname/Prefer to be Called: _____
Email: _____
Cell #: _____ Work #: _____ Ext: _____
Home Address: _____ City _____ State _____ Zip _____
Who Shall we Thank for your Visit Today: _____
Their Phone # : _____

Dental Insurance Information

Are your the Policy Holder: Yes No
If No, Name of Primary Policy Holder: _____ Relationship: _____

Dental Insurance Company: _____ Group #: _____
Member ID: _____ Toll-Free Insurance Phone Number: _____
Primary's SSN: _____ Primary's D.O.B.: _____
Drivers License #: _____
Employer: _____
Occupation: _____
Work Address: _____ City _____ State _____ Zip _____
Are you the Primary Responsible for Payment: Yes No
If No, Name of Primary Responsible: _____ Phone #: _____

Dental History

Any particular reason for your Visit Today? {General, Cosmetic Dental, or Spa Services}

_____

How long since your last Dental Cleaning: _____
How often do you normally get your teeth cleaned: _____
Yes No Are you allergic to Latex or any other dental materials? _____
Yes No Have you ever experienced any unfavorable reaction to dental work? _____
Yes No Have you ever lost or chipped any teeth? How? _____
Yes No Are your teeth sensitive {Which one? sweets, pressure, heat} _____
Yes No Do you use an Electronic toothbrush? _____
Yes No Are you a mouth breather or have "dry mouth"? Due to? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you wake up? _____
Yes No Are you aware of any popping or clicking in your jaws? _____
Yes No Do you ever clench or grind your teeth? _____
Yes No Do you have limited jaw opening? Why? _____
Yes No Have your ever used Botox or any Fillers in your face? Where/Last time? _____
Yes No Do your gums bleed when you brush or floss? _____
Yes No Does food pack or catch in between your teeth? _____
Yes No Do you have any difficulty chewing or swallowing? _____
Yes No Do you smoke? _____
Yes No Have you ever had your teeth whitened? Last time? _____
Yes No Have you ever worn braces? When? _____ Wear Retainers? _____
Yes No Would you be opposed to wearing clear braces or retainers should they be indicated? _____
Yes No Have you ever had a Facial? _____

Health History

Are you taking ANY medications now {including daily dosages of aspirin}? Yes No

If so, please list name and dosage:_____

_____

Are you aware of having any drug allergies? Yes No

If so please list them & reaction:_____

_____

Do you have a history of a major illness?_____

Have you had any major operations?_____

Are you pregnant or planning to be pregnant? Yes No If Yes, How many months?_____

Please indicate which of the following you have had, or currently have.

***Please Circle "YES" or "NO"** to each item. Please do not leave any un-circled. If YES, Please explain in given space. Thank-You!

Any Heart Concerns	Yes	No	Mitral Valve Prolapse	Yes	No
High blood pressure	Yes	No	Congenital Heart Disease	Yes	No
Artificial Heart Valve	Yes	No	Heart Murmur	Yes	No
Pacemaker	Yes	No	Stroke	Yes	No
Artificial joints	Yes	No	Kidney Trouble	Yes	No
History of Cancer/Tumor	Yes	No	Radiation/Chemotherapy	Yes	No
Epilepsy /seizures	Yes	No	Bone Disorders	Yes	No
Diabetes Yes No	Controlled?	Yes No	Herpes {Type I or II}	Yes	No
AIDS/HIV	Yes	No	Anemia/Blood Disorders	Yes	No
Tingling in arms/fingers	Yes	No	Sickle Cell Disease	Yes	No
Insomnia/frequent waking	Yes	No	Headaches	Yes	No
Congested/Ringing Ears	Yes	No	Neurological/Nervous Disorders	Yes	No
Dizziness	Yes	No	Asthma	Yes	No
Liver disease/ Jaundice/Hepatitis	Yes	No	Gastrointestinal/Reflux Disorders	Yes	No

Do you have or have you had any disease, condition or problem not discussed here that we should be aware of?

_____

_____

Emergency Contact: Name: _____ Phone #: _____

Client Name (Print): _____

Client Signature:_____ Date:_____

April N. Patterson, D.D.S._____ Date: _____