Date ______________ **PATIENT INFORMATION AND HEALTH HISTORY**

**HOW DID YOU FIND OUT ABOUT OUR OFFICE?** ______________________________

**PERSONAL INFORMATION**

PATIENT NAME ______________________________
FIRST MIDDLE LAST

PATIENT DATE OF BIRTH ______________________ PATIENT SS# ________-_____-_______

HOME ADDRESS ______________________ HOME PHONE ( ) ______________

CITY ______________ STATE _______ ZIP ________ BUS. PHONE ( ) ____________ ext____

PATIENT EMPLOYED BY ______________________ CELL PHONE ( ) ______________

BUSINESS ADDRESS ______________ CITY __________ ZIP _______ E-MAIL ___________

NEAREST RELATIVE/
EMERGENCY CONTACT ______________ PHONE ( ) __________ CELL ( ) __________

**DO YOU HAVE INSURANCE THAT MAY COVER ANY PART OF OUR SERVICES? YES ________ NO ________**
(If no skip to dental information)

**DENTAL INSURANCE INFORMATION**

NAME OF YOUR DENTAL INSURANCE COMPANY ______________________ Gp# __________

NAME OF SUBSCRIBER ____________ YOUR RELATIONSHIP TO SUBSCRIBER SPOUSE ❑ CHILD ❑ SELF ❑

SUBSCRIBER DATE OF BIRTH ______________________ INSURED SS# ________-_____-_______

EMPLOYER ______________________________ BUS. PHONE ( ) ______________

BUSINESS ADDRESS ____________________ CITY ______________ ZIP __________

**SECONDARY DENTAL INSURANCE COMPANY**

NAME OF INSURANCE COMPANY ______________________ Gp# ______________

NAME OF INSURED ______________________________

INSURED DATE OF BIRTH ______________________ INSURED SS# ________-_____-_______

INSURED EMPLOYER ______________________ BUS. PHONE ( ) ______________

**DENTAL INFORMATION**

DO YOUR GUMS BLEED WHEN YOU BRUSH/OR FLOSS? YES _______ NO _______

DO YOU HAVE CHRONIC BAD BREATH? YES _______ NO _______

ARE YOUR TEETH SENSITIVE TO HEAT OR COLD? SWEETS? OR BITING DOWN? YES _______ NO _______

DO YOU GRIND OR CLENCH YOUR TEETH? YES _______ NO _______

HAVE YOU EVER HAD A BAD DENTAL EXPERIENCE? YES _______ NO _______

DATE OF LAST EXAMINATION ______________ DATE OF LAST X-RAYS ______________

HOW DO YOU FEEL ABOUT THE APPEARANCE OF YOUR TEETH? WOULD YOU LIKE TO IMPROVE THEM? ______

______________________________

HOW WOULD YOU DESCRIBE YOUR CURRENT DENTAL PROBLEM? ______________________________

______________________________

HOW WOULD YOU LIKE TO SEE US CORRECT YOUR DENTAL PROBLEM?

______________________________

______________________________

***For your health's sake, you must be accurate:***

**Physician Name**________________________________________

**Phone** ____________________________________________

**MEDICAL HISTORY**

**CIRCLE**

1. Have you been a patient in the hospital during the past two years? __________________ YES NO
2. Have you been under the care of a medical doctor during the past two years? ____________ YES NO
3. Have you taken Phen-Fen during the past two years? __________________________ YES NO
4. Have you had an EKG? _________________________________________________ YES NO
5. Have you ever been advised to pre-medicate prior to dental treatment? _________________ YES NO
6. Are you allergic to penicillin, aspirin, codeine, latex or other (please circle or list)? __________________
7. List any medications you are taking ________________________________________________
8. Have you ever had excessive bleeding requiring special treatment? ____________________ YES NO
9. Circle yes or no for each of the following which you have had or have at present.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart Failure | YES | NO | Ulcers | YES | NO | AIDS | YES | NO |
| Heart Disease or Attack | YES | NO | Emphysema | YES | NO | Hepatits A (infectious) | YES | NO |
| Angina Pectoris (Chest Pains) | YES | NO | Chronic Bronchitis | YES | NO | Hepatitis B (serum) | YES | NO |
| High Blood Pressure | YES | NO | Tuberculosis | YES | NO | Liver Disease | YES | NO |
| Heart Murmur | YES | NO | Asthma | YES | NO | Blood Transfusion | YES | NO |
| Rheumatic/Scarlet Fever | YES | NO | Hay Fever/Sinus Trouble | YES | NO | Drug or Alcohol Abuse | YES | NO |
| Conginital Heart Lesions | YES | NO | Allergies or Hives | YES | NO | Hemophilia | YES | NO |
| Artificial Heart Valve | YES | NO | Diabetes | YES | NO | VD (Syphilis, Gonorrhea) | YES | NO |
| Mitral Valve Prolapse (MVP) | YES | NO | Thyroid Disease | YES | NO | Cold Sores | YES | NO |
| Heart Pacemaker | YES | NO | X-ray or Cobalt Treatment | YES | NO | Genital Herpes | YES | NO |
| Heart Surgery | YES | NO | Chemo (Cancer, Leukemia) | YES | NO | Epilepsy or Seizures | YES | NO |
| Artificial Joints | YES | NO | Arthritis | YES | NO | Fainting or Dizzy Spells | YES | NO |
| Anemia | YES | NO | Cortisone Medicine | YES | NO | Nervousness | YES | NO |
| Stroke | YES | NO | Glaucoma | YES | NO | Psychiatric Treatment | YES | NO |
| Kidney Trouble | YES | NO | Pain in Jaw Joints | YES | NO | Bruise Easily | YES | NO |

10. Do you ever wake up from sleep short of breath? ____________________________ YES NO
11. Are you on a special diet? _____________________________________________ YES NO
12. Has your medical doctor ever said you have a cancer or tumor? _____________________ YES NO
13. Do you have any disease, condition or problem not listed? ________________________ YES NO
14. WOMEN: Are you pregnant now? _________________________________________ YES NO

    Do you anticipate becoming pregnant? ___________________________________ YES NO

    Are you taking birth control? __________________________________________ YES NO

    ***Please be advised that many antibiotics may lessen the effects of oral contraception.***

**Please describe 'yes' answers** ________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

*To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail. I understand that the doctor reserves the right to charge $100.00 for appointments cancelled or broken without 24 hour advance notice.*

DATE ______________________ SIGNATURE ___________________________________________

I hereby grant complete authority to Dr. Day to administer any treatment and to administer such x-rays, anesthetics, and to perform such dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition.

DATE ______________________ SIGNATURE ___________________________________________

____________________________________________________________________________

____________________________________________________________________________