South Main Dental

Patient History Form

Patients First Name _____ **MI** ____ **Last Name** _____

ABOUT YOU

◯ Female ◯ Male

Todays date _____
E-mail address _____
I Prefer to be called _____
Birth date _____ Age ____ SS# _____
Address _____ Apt # _____
City _____ State _____ Zip _____
Phone-Home _____ Cell _____
Work phone _____ Ext.# _____
Employer _____
Address _____
Occupation _____
Where and when best times to reach you? _____

_____

Referred by _____
Other family members seen by us _____
Previous dentist _____
Last visit date _____

ABOUT SPOUSE

Name-First _____ Last _____
Birth date _____ Age ____ SS# _____
Phone-Home _____ Cell _____
Phone-Work _____ Ext.# _____
Employer _____

WHO IS RESPONSIBLE FOR YOUR ACCOUNT

Name-First _____ Last _____
Relation _____
SS# _____ Driver's license # _____
Work phone _____ Ext.# _____
Cell phone _____
Employer _____

WHO SHOULD WE CONTACT IN AN EMERGENCY?

Name-First _____ Last _____
Relationship _____
Phone-Home _____ Cell _____

PRIMARY INSURANCE COVERAGE

Dental coverage? ◯ Yes ◯ No
Insurance name _____
Insurance address _____

_____

Insurance phone _____
Group #, plan, local or policy #

_____

Insureds name _____
Insureds relation to patient _____
Insureds birth date _____
Insureds subscriber ID _____
Insureds employer _____

_____

SECONDARY INSURANCE COVERAGE

Dental coverage? ◯ Yes ◯ No
Insurance name _____
Insurance address _____

_____

Insurance phone _____
Group #, plan, local or policy #

_____

Insureds name _____
Insureds relation to patient _____
Insureds birth date _____
Insureds subscriber ID _____
Insureds employer _____

_____

YOUR MEDICAL CARE

Do you have a personal physician?
◯ Yes ◯ No
Physician's name _____
Physician's phone _____
Date of last visit _____
Are you currently under the care of a physician? ◯ Yes ◯ No
If yes, please explain _____

_____

_____

Your current physical health is:
◯ Good ◯ Fair ◯ Poor

Patients First Name MI Last Name

WHY HAVE YOU COME TO THE DENTIST TODAY?

List reasons here: _____

HEALTH INFORMATION

Have you ever taken Fosamax, Actonel, Boniva, or any other biphosphonate? ◯ Yes ◯ No

Do you take prescription, over-the-counter, or herbal supplement drugs? ◯ Yes ◯ No

If YES, list each one: _____

FOR WOMEN

◯ Yes ◯ No Are you using a prescribed birth control method?

◯ Yes ◯ No Are you pregnant?

◯ Yes ◯ No Are you nursing?

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

◯Yes ◯No Abnormal Bleeding
◯Yes ◯No Alcohol/Drug Abuse
◯Yes ◯No Anemia
◯Yes ◯No Arthritis
◯Yes ◯No Artificial Bones, Joints, Valves
◯Yes ◯No Asthma
◯Yes ◯No Blood Transfusion
◯Yes ◯No Cancer, Chemotherapy
◯Yes ◯No Colitis
◯Yes ◯No Congenital Heart Defect
◯Yes ◯No Diabetes
◯Yes ◯No Difficulty Breathing
◯Yes ◯No Emphysema
◯Yes ◯No Epilepsy
◯Yes ◯No Fainting Spells
◯Yes ◯No Frequent Headaches
◯Yes ◯No Glaucoma
◯Yes ◯No Hay Fever
◯Yes ◯No Heart Attack
◯Yes ◯No Heart Murmur
◯Yes ◯No Heart Surgery
◯Yes ◯No Hemophilia
◯Yes ◯No Hepatitis
◯Yes ◯No Herpes, Fever Blisters
◯Yes ◯No High Blood Pressure
◯Yes ◯No HIV positive, AIDS
◯Yes ◯No Hospitalized for Any Reason
◯Yes ◯No Kidney Problems
◯Yes ◯No Liver Disease
◯Yes ◯No Low Blood Pressure
◯Yes ◯No Mitral Valve Prolapse
◯Yes ◯No Pacemaker
◯Yes ◯No Psychiatric Problems
◯Yes ◯No Radiation Treatments
◯Yes ◯No Rheumatic / Scarlet Fever
◯Yes ◯No Seizures
◯Yes ◯No Shingles
◯Yes ◯No Sickle Cell Disease / Traits
◯Yes ◯No Sinus Problems
◯Yes ◯No Stroke
◯Yes ◯No Thyroid Problems
◯Yes ◯No Tuberculosis (TB)
◯Yes ◯No Ulcers
◯Yes ◯No Venereal Disease

List any other serious medical conditions that you have ever had: _____

Patients First Name MI Last Name

SLEEP

◯ Yes ◯ No Do you snore while sleeping
◯ Yes ◯ No Have you been diagnosed/treated for sleep apnea?
◯ Yes ◯ No Do you use a CPAP or other appliance?

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

◯ Yes ◯ No Aspirin
◯ Yes ◯ No Codeine
◯ Yes ◯ No Dental Anesthetics
◯ Yes ◯ No Erythromycin
◯ Yes ◯ No Jewelry
◯ Yes ◯ No Latex
◯ Yes ◯ No Metals
◯ Yes ◯ No Penicillin
◯ Yes ◯ No Tetracycline

List any other drugs or materials that you are allergic to: _____

◯ Yes ◯ No Have you ever had a serious or difficult problem associated with previous dental work?
◯ Yes ◯ No Do you require antibiotics before dental treatment?
◯ Yes ◯ No Are you currently in pain?
◯ Yes ◯ No Do your gums ever bleed?
◯ Yes ◯ No Do you like your smile?
◯ Yes ◯ No Would you like whiter teeth?
◯ Yes ◯ No Fresher Breath?
◯ Yes ◯ No Have you ever had pain or discomfort in your jaw joint?
◯ Yes ◯ No Do you smoke or use tobacco?

How many times a week do you floss? _____

How many times a day do you brush? _____

What type of tooth brush bristles:
◯ Soft ◯ Medium ◯ Hard

Your current dental health is:
◯ Good ◯ Fair ◯ Poor

Additional comments: _____

CONSENT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Payment is due at time of service unless prior arrangements have been made. I understand that I am responsible for payment of services rendered and also responsible of any copay and deductibles that my insurance does not cover.

Signature _____ Date _____