Patient Information

Date _____

Full Name _____ Birth Date _____ Marital Status _____
Home Address _____ Zip _____ Home Phone _____
Occupation _____ Employer _____ Social Security No. _____
Business Address _____ Zip _____ Work Phone _____
Name of Spouse _____ Occupation _____ Employer _____
Dental Insurance Company _____ Policy No. _____
Referred By _____ Previous Dentist _____
Name of Physician _____ Phone No. _____
In Case of Emergency Contact _____ Phone No. _____

Patient Name _____

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____

Approximate date of last physical examination _____

		Yes	No
1.	Are you under any medical treatment now?	☐	☐
2.	Have you had any major operations? If so what?	☐	☐
3.	Have you ever had a serious accident involving head injuries?	☐	☐
4.	Have you had any adverse response to any drugs including penicillin?	☐	☐
5.	Has a physician ever informed you that you had: A Heart Ailment?	☐	☐
6.	High Blood Pressure?	☐	☐
7.	Respiratory Disease?	☐	☐
8.	Diabetes?	☐	☐
9.	Rheumatic Fever?	☐	☐
10.	Rheumatism or Arthritis?	☐	☐
11.	Tumors or Growths?	☐	☐
12.	Any Blood Disease?	☐	☐
13.	Any Liver Disease?	☐	☐
14.	Any Kidney Disease?	☐	☐
15.	Any Stomach or Intestinal Disease?	☐	☐
16.	Any Venereal Disease?	☐	☐
17.	AIDS?	☐	☐
18.	Yellow Jaundice or Hepatitis?	☐	☐
19.	Do you have night sweats accompanied by weight loss or cough?	☐	☐
20.	Have you ever taken Phen-Phen medication?	☐	☐
21.	Are you now taking drugs or medications?	☐	☐
22.	Are you allergic to any known materials resulting in hives, asthma, eczema, etc.?	☐	☐
23.	Are you allergic to latex?	☐	☐
24.	Have any wounds healed slowly or presented other complications?	☐	☐
25.	Are you pregnant?	☐	☐
26.	Do you have a history of fainting?	☐	☐
27.	Have you ever taken Fosamax, Boniva or any other Bisphosphonate for Osteoporosis?	☐	☐

PATIENT DENTAL HISTORY

28.	Do you have pain in or near your ears?	☐	☐
29.	Do you have any unhealed injuries or inflamed areas in or around your mouth?	☐	☐
30.	Have you experienced any growth or sore spots in your mouth?	☐	☐
31.	Have you ever had Novocaine anesthetic?	☐	☐
32.	Any reactions or allergic symptoms to Novocaine?	☐	☐
33.	Any difficult extractions in the past?	☐	☐
34.	Prolonged bleeding following extractions in the past?	☐	☐
35.	Do your gums bleed?	☐	☐

36. When was your last full mouth X-RAY taken? _____ Where? _____

INFORMED CONSENT

I, the undersigned, consent to Dr. Thompson and any of his assistants to perform dental treatment. If any unforseen condition arises in the course of treatment calling, in his judgment for procedures in addition to, or different from those now contemplated, I request and authorize him to do whatever he deems advisable. Although a satisfactory result is expected from all dental treatment, no guarantee or assurance has been given to anyone as to the results that may be obtained.

Signature _____