

PATIENT INFORMATION SHEET

PATIENT

Mr. Mrs. Ms. Dr. _____
Last _____ First _____ M.I. _____
Age _____ Date of Birth ____/____/____
Address _____ City _____ State ____ Zip _____
Home phone (____) ____ - ____ Cell (____) ____ - ____ Work (____) ____ - ____
Occupation _____ Social Security # ____ - ____ - ____
Drivers License # _____ Employed by _____
If Student, where? _____
Spouse's name _____ Social Security # ____ - ____ - ____
Date of Birth ____/____/____ Occupation _____
Employed by _____ Work phone (____) ____ - ____
Person financially responsible for account? _____ Phone (____) ____ - ____
In case of emergency contact _____ Phone (____) ____ - ____
Relationship _____
Patient's dentist _____ Phone (____) ____ - ____
Referred by _____
Patient's physician _____ Phone (____) ____ - ____
Last physical exam ____/____/____
Dental insurance _____ Policy # _____ Subscriber _____
Medical insurance _____ Policy # _____ Subscriber _____

IF A MINOR

Parent's name _____ Soc. Sec. # ____ - ____ - ____
Date of Birth ____/____/____ Employed by _____ Phone (____) ____ - ____

PATIENT HEALTH HISTORY

Please answer all questions. Don't understand? Aren't sure? Please leave it BLANK.

Your Height _____
Your Weight _____

1. YES NO Is your general health good?
2. YES NO Has there been a change in your health within the last year?
3. YES NO Have you been hospitalized or had a serious illness in the last three years? Please explain:

4. YES NO Are you being treated by a physician now? If so, for what?

5. YES NO Have you had problems with prior dental treatment? Please explain:

6. YES NO Are you in pain now?

HAVE YOU EXPERIENCED?

- | | | | | | | | |
|-----|-----|----|--|-----|-----|----|------------------------|
| 7. | YES | NO | Chest pain or angina? | 18. | YES | NO | Dizziness? |
| 8. | YES | NO | Swollen ankles? | 19. | YES | NO | Ringing in ears? |
| 9. | YES | NO | Shortness of breath? | 20. | YES | NO | Headaches? |
| 10. | YES | NO | Recent weight loss, fever, night sweats? | 21. | YES | NO | Fainting spells? |
| 11. | YES | NO | Persistent cough, coughing up blood? | 22. | YES | NO | Blurred vision? |
| 12. | YES | NO | Bleeding problems, bruising easily? | 23. | YES | NO | Seizures? |
| 13. | YES | NO | Sinus problems? | 24. | YES | NO | Excessive thirst? |
| 14. | YES | NO | Difficulty swallowing? | 25. | YES | NO | Frequent urination? |
| 15. | YES | NO | Anxiety attacks? | 26. | YES | NO | Dry mouth? |
| 16. | YES | NO | Frequent vomiting, nausea? | 27. | YES | NO | TMJ problems? |
| 17. | YES | NO | Difficulty urinating, blood in urine? | 28. | YES | NO | Joint pain, stiffness? |

DO YOU HAVE, OR HAVE YOU EVER HAD?

- | | | | | | | | |
|-----|-----|----|---|-----|-----|----|---------------------------------|
| 29. | YES | NO | Heart murmurs? | 36. | YES | NO | Bleeding or clotting problems? |
| 30. | YES | NO | Heart attack, heart disease, heart defects? | 37. | YES | NO | Hepatitis A, B, or C, jaundice? |
| 31. | YES | NO | High blood pressure? | 38. | YES | NO | Liver disease or tumor? |
| 32. | YES | NO | Delayed healing? | 39. | YES | NO | Blood transfusions? |
| 33. | YES | NO | Bypass surgery? | 40. | YES | NO | Anemia? |
| 34. | YES | NO | Prosthetic heart valve? | 41. | YES | NO | Stomach problems, ulcers? |
| 35. | YES | NO | Pacemaker? | 42. | YES | NO | Arthritis, rheumatism? |

DO YOU HAVE, OR HAVE YOU EVER HAD?

- | | | | | | | | |
|-----|-----|----|--|-----|-----|----|---------------------------|
| 43. | YES | NO | TB, emphysema, asthma, lung diseases? | 52. | YES | NO | Diabetes? |
| 44. | YES | NO | Allergies: food, drugs, latex products? | 53. | YES | NO | Kidney, bladder disease? |
| 45. | YES | NO | Allergies: local or general anesthetics? | 54. | YES | NO | Surgeries? |
| 46. | YES | NO | Artificial joint? | 55. | YES | NO | Hospitalization? |
| 47. | YES | NO | Tumors, cancer? | 56. | YES | NO | Eye diseases? |
| 48. | YES | NO | Chemotherapy or radiation treatments? | 57. | YES | NO | Frequent skin infections? |
| 49. | YES | NO | Psychiatric care? | 58. | YES | NO | AIDS or HIV? |
| 50. | YES | NO | Substance abuse problems? | 59. | YES | NO | Herpes? |
| 51. | YES | NO | Thyroid, adrenal disease? | 60. | YES | NO | Venereal disease? |

ARE YOU USING, OR HAVE YOU EVER USED?

- | | | | | | | | |
|-----|-----|----|----------------------|-----|-----|----|---------------------|
| 61. | YES | NO | Tobacco in any form? | 63. | YES | NO | Recreational drugs? |
| 62. | YES | NO | Alcohol? | 64. | YES | NO | ANY diet drugs? |

