

PATIENT INFORMATION

Patient Name Date of Birth Age Today's Date

Miss Mr. Mrs. Ms. Dr. I prefer to be called _____ Male Female

Home Address City State Zip

Single Married Divorced Widowed Separated SS# ____ - ____ - ____ DL# _____

Home Phone Cell Work Ext Email

Employer Address Occupation How long?

Where and when can we reach you? _____

Other family members seen by us? _____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Primary Dental Insurance Insurance Company Name Group/Plan/Local/Policy#

Address Phone

Insured's Name Relation

Insured's date of birth? Insured's SS# ____ - ____ - ____ Insured's Employer

In the event of an emergency, is there someone that lives near you that we should contact?

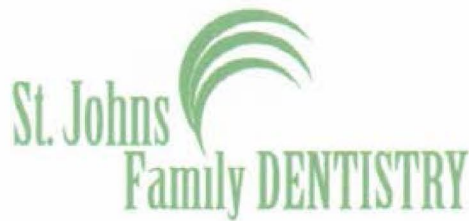
Name Relation Home Phone Work / Cell

How did you hear about St. Johns Family Dentistry?

Yellow Pages Mail / Coupon Referral Internet TV Billboard Drive-By

Other _____

Whom may we thank for referring you? _____



MEDICAL & DENTAL HISTORY

Patient Name

Date of Birth:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important relationship with the dentistry you will receive. Thank you for answering the following questions accurately and honestly.

I have come to the dentist today because:

- | | | | |
|--|---|---|---|
| Are you currently in pain? | <input type="radio"/> Y <input type="radio"/> N | Are you currently under a physician's care? | <input type="radio"/> Y <input type="radio"/> N |
| Have you ever had a serious or difficult problem associated with any previous dental work? | <input type="radio"/> Y <input type="radio"/> N | Have you been hospitalized or had a major operation? | <input type="radio"/> Y <input type="radio"/> N |
| Discomfort in your jaw joint (TMJ I TMD)? | <input type="radio"/> Y <input type="radio"/> N | Have you ever had a serious head or neck injury? | <input type="radio"/> Y <input type="radio"/> N |
| Your assessment of your current health is: <i>Good Fair Poor</i> | | Are you on a special diet? | <input type="radio"/> Y <input type="radio"/> N |
| How many times a week do you floss? | _____ | Do you use controlled substances? | <input type="radio"/> Y <input type="radio"/> N |
| How many times a day do you brush? | _____ | Do you smoke or use tobacco? | <input type="radio"/> Y <input type="radio"/> N |
| Do your gums ever bleed? | <input type="radio"/> Y <input type="radio"/> N | Do you take or have you taken medication for bone loss: | |
| Have you ever had periodontal (gum) treatment? | <input type="radio"/> Y <input type="radio"/> N | Bisphosphonate Derivative (Fosomax, Boniva) | <input type="radio"/> Y <input type="radio"/> N |
| Type of tooth brush? <i>Rotary Hard Medium Soft</i> | | Women: <i>Are you pregnant?</i> | <input type="radio"/> Y <input type="radio"/> N |
| | | <i>Taking Oral Contraceptives?</i> | <input type="radio"/> Y <input type="radio"/> N |
| | | <i>Nursing?</i> | <input type="radio"/> Y <input type="radio"/> N |

Please explain any "YES" answers: _____

List all current medications: _____

Previous / Present Dentist: _____ **Last visit date** _____

Previous / Present Physician: _____ **Last visit date** _____

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other allergies: _____

Do you have or have had any of the following? (Please circle all that apply)

- | | | | | |
|------------------------|---------------------------|-----------------------|-----------------------|----------------------------|
| AIDS/HIV | Chest Pains Lung Disease | Genital Herpes | Leukemia | Sinus Trouble |
| Alzheimer's disease | Cold Sores/Fever Blisters | Glaucoma | Liver Disease | Spina Bifida |
| Anaphylaxis | Congenital Heart Disorder | Hay Fever | Low Blood Pressure | Stomach/Intestinal Disease |
| Anemia Convulsions | Cortisone Medicine | Heart Attack/Failure | Mitral Value Prolapse | Stroke |
| Angina | Drug Addiction | Heart Murmur | Pain in Jaw Joints | Swelling of Limbs |
| Arthritis/Gout | Easily Winded | Heart Pace Maker | Parathyroid Disease | Thyroid Disease |
| Artificial Heart Valve | Emphysema | Heart Trouble/Disease | Psychiatric Care | Tonsillitis |
| Artificial Joint | Epilepsy or Seizures | Hemophilia | Radiation Treatment | Tuberculosis |
| Asthma Hives or Rash | Excessive Bleeding | Hepatitis A | Recent Weight Loss | Tumors or Growths |
| Blood Disease | Fainting I Dizziness | Hepatitis B or C | Renal Dialysis | Ulcers |
| Blood Transfusion | Frequent Cough | Herpes | Rheumatic Fever | Venereal Disease |
| Breathing Problems | Frequent Diarrhea | High Blood Pressure | Rheumatism | Yellow Jaundice |
| Bruise Easily | Frequent Headaches | Hypoglycemia Diabetes | Scarlet Fever | |
| Cancer | | Irregular Heartbeat | Shingles | |
| Chemotherapy | | Kidney Problems | Sickle Cell Disease | |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient, Parent, or Guardian Signature

Date