# GENERAL HEALTH INFORMATION

DATE: _____ **CHART #** _____

PATIENT NAME: _____ BIRTH DATE: _____ AGE: _____
LAST FIRST

## DENTAL HISTORY

1. **Reason for Visit / Main Concern**? Check-Up ☐ Cleaning ☐ Toothache ☐ Other _____
2. Are there other conditions of which we should be aware? YES ◯ NO ◯ If yes, please specify: _____
3. When did you last visit a dentist? _____ 4. What treatment was performed? _____
5. Was the treatment completed? _____ 6. When were dental x-rays taken? _____
7. Did you have a cleaning ? YES ◯ NO ◯ 8. Have you had gum (periodontal) treatment? YES ◯ NO ◯
9. Have you ever had prolonged bleeding after an extraction? YES ◯ NO ◯ If yes, please specify: _____
10. Have you had any problems with past dental treatment? YES ◯ NO ◯ If yes, please specify: _____
11. Do you grind your teeth, clinch your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open? YES ◯ NO ◯ If yes, please specify: _____
12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ? YES ◯ NO ◯ If yes, please specify: _____
13. Do your gums bleed easily? YES ◯ NO ◯ 14. Do you feel you have bad breath? YES ◯ NO ◯
15. Are your teeth sensitive to hot or cold? YES ◯ NO ◯ 16. Would you like your teeth whiter? YES ◯ NO ◯
17. Are you happy with your smile? YES ◯ NO ◯ If no, please explain: _____

## MEDICAL HISTORY

1. Are you under a Doctor's care at this time? YES ◯ NO ◯ If yes, please specify: _____ Dr. Name: _____
   Dr. Phone: ( ) _____
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? _____
3. Are you taking any medications at this time, including birth control? YES ◯ NO ◯ If yes, please specify: _____
4. (Women) Are you pregnant now? YES ◯ NO ◯ If yes, how many months? _____ Are you nursing? YES ◯ NO ◯
5. Are there any other health problems of which we should be advised? Please specify: _____
6. Do you have, or have you had, any of the following?

| Please check "YES" or "NO" | | | Doctor Comments | Please check "YES" or "NO" | | | Doctor Comments |
|---|---|---|---|---|---|---|---|
| ARTIFICIAL HEART VALVE | YES ◯ | NO ◯ | | HIGH BLOOD PRESSURE | YES ◯ | NO ◯ | |
| AIDS/HIV+ | YES ◯ | NO ◯ | | JAUNDICE | YES ◯ | NO ◯ | |
| ANEMIA | YES ◯ | NO ◯ | | JOINT REPLACEMENT | YES ◯ | NO ◯ | |
| ANGINA | YES ◯ | NO ◯ | | KIDNEY DISEASE | YES ◯ | NO ◯ | |
| ARTHRITIS | YES ◯ | NO ◯ | | LATEX ALLERGY | YES ◯ | NO ◯ | |
| ASTHMA | YES ◯ | NO ◯ | | LIVER PROBLEMS | YES ◯ | NO ◯ | |
| BISPHOSPHONATE THERAPY | YES ◯ | NO ◯ | | LOW BLOOD PRESSURE | YES ◯ | NO ◯ | |
| BLEEDING PROBLEMS | YES ◯ | NO ◯ | | LUNG DISEASE | YES ◯ | NO ◯ | |
| CANCER | YES ◯ | NO ◯ | | PACEMAKER | YES ◯ | NO ◯ | |
| CHEMO/RAD THERAPY | YES ◯ | NO ◯ | | PHEN-FEN/REDUX | YES ◯ | NO ◯ | |
| COSMETIC SURGERY | YES ◯ | NO ◯ | | PSYCHIATRIC CARE | YES ◯ | NO ◯ | |
| DIABETES | YES ◯ | NO ◯ | | RHEUMATIC FEVER | YES ◯ | NO ◯ | |
| DIZZY SPELLS/FAINTING | YES ◯ | NO ◯ | | SINUS TROUBLE | YES ◯ | NO ◯ | |
| DRUG ADDICTION | YES ◯ | NO ◯ | | SLEEP APNEA | YES ◯ | NO ◯ | |
| EMPHYSEMA | YES ◯ | NO ◯ | | TOBACCO | YES ◯ | NO ◯ | |
| EPILEPSY | YES ◯ | NO ◯ | | STROKE | YES ◯ | NO ◯ | |
| GLAUCOMA | YES ◯ | NO ◯ | | THYROID PROBLEMS | YES ◯ | NO ◯ | |
| HEART ATTACK/SURGERY | YES ◯ | NO ◯ | | TMD OR TMJ | YES ◯ | NO ◯ | |
| HEART MURMUR/PROBLEMS | YES ◯ | NO ◯ | | TUBERCULOSIS | YES ◯ | NO ◯ | |
| HEPATITIS | YES ◯ | NO ◯ | | VENEREAL DISEASE | YES ◯ | NO ◯ | |

*To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.*

Patient's signature _____ Date _____
(Parent if Patient is a Minor)

Doctor Signature _____

**MEDICAL UPDATE:**

1. Patient's signature _____ Doctor's Signature _____ Date _____
2. Patient's signature _____ Doctor's Signature _____ Date _____
3. Patient's signature _____ Doctor's Signature _____ Date _____

# PATIENT INFORMATION CHART # _____

## PATIENT

Name _____
Last First

Address _____ Apt. # _____

City _____ Zip _____

How long at this address? _____

Phone ( ) _____

Cell/Pager ( ) _____

E-mail _____

Social Security # _____

DL# _____

Age _____ Birthdate _____

Primary Language _____

Ethnicity _____

## GETTING TO KNOW YOU

Do you have family members who may need dental care?
If so, please list name & relationship (son, daughter, husband)

1: _____ 2: _____

3: _____ 4: _____

**How did you hear about our office? (Circle one)**

**Family-Friend (400)** ☐
**ConfiDent© (440)** ☐
**Newspaper (470)** ☐
**Billboard (050)** ☐
**Flyer-Coupon (490)** ☐
**Office Sign (420)** ☐
**Office Transfer (430)** ☐
**Insurance Plan (460)** ☐
**Television (020)** ☐
**Radio (030)** ☐
**Yellow Pages (120)** ☐
**Direct Mail Postcard (480)** ☐
**Internet-Website (190)** ☐

I want information in Spanish: YES_____ NO_____

## EMPLOYMENT

Occupation _____

Employer _____

How Long? _____

Business Address _____

City _____ Zip _____

Business Phone ( ) _____ Ext. # _____

Verified By _____ Date _____
(Office use only)

## REFERENCES

Name _____
Last First

Phone ( ) _____

Name _____

Phone ( ) _____

Spouse's Name _____
Last First

Spouse's Work Phone ( ) _____

## PERSON TO CONTACT FOR EMERGENCY:

_____
Last First

Phone ( ) _____

Physician _____ Phone ( ) _____

## RESPONSIBLE PARTY (If same as above, please skip)

Name _____
Last First

Address _____ Apt. # _____

City _____ Zip _____

How long at this address? _____

Phone ( ) _____

Social Security # _____ DL# _____

Relationship to Patient _____

Age _____ Birthdate _____

## INSURANCE / DENTAL PLAN

**Primary:** Insurance ☐ PPO ☐ HMO ☐ (Check one)

Plan Name _____

Address _____

City, Zip _____

Insurance / Plan Phone # _____

Employer _____

Union/Local _____ Group # _____ Plan# _____

Insured's Name _____

Insured's Soc. Sec. # _____ Birthdate _____

## INSURANCE / DENTAL PLAN

**Secondary:** Insurance ☐ PPO ☐ HMO ☐ (Check one)

Plan Name _____

Address _____

City, Zip _____

Insurance / Plan Phone # _____

Employer _____

Union/Local _____ Group # _____ Plan# _____

Insured's Name _____

Insured's Soc. Sec. # _____ Birthdate _____

## INSURANCE / MEDICAL PLAN

**Primary:** Insurance ☐ PPO ☐ HMO ☐ (Check one)

Plan Name _____

Address _____

City, State, Zip _____

Insurance / Plan Phone # _____

Employer _____

Union/Local _____ Group # _____ Plan# _____

Insured's Name _____

Insured's Soc. Sec. # _____ Birthdate _____

1. I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.

2. By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.

3. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.

4. I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

5. By signing below, I authorize that you may send me email and text message appointment reminders, marketing material, and account updates, including electronic billing statements.

_____
Signature of Responsible Party or Patient (Parent if Patient is a Minor) Date