

(This information is necessary for our files and your health and will be considered CONFIDENTIAL)

PATIENT INFORMATION

Date Patient name Address City State Zip Code E-mail Sex Married Widowed Single Minor Separated Divorced Partnered SS# Occupation Patient employer/school Employer/School Address Spouse's/Parent(s) Name(s) Spouse's Employer Whom may we thank for referring you?

CONTACT INFORMATION

Home Work Ext Cell Spouse's work Best time and place to reach you

IN CASE OF EMERGENCY, CONTACT (specify someone who does not live in your household.)

Name Relationship Home Work Ext Cell

DENTAL INSURANCE

Subscriber's Name Relationship to Patient Birthdate SS# Insurance Co Group # Phone # Is Patient covered by Secondary Insurance Subscriber's Name Relationship to Patient Birthdate SS# Insurance Co Group # Phone #

DENTAL HISTORY

Reason for today's visit Former Dentist City, State Date of last dental visit Date of last dental x-rays How often do you floss? How often do you brush? Would you describe your present dental health as good? Do you think you have active decay or gum disease? Do you feel nervous about having dental treatment? Have you ever had a bad experience in a dental office? Do you want to keep your remaining teeth? Do you like your smile? Why? Have you ever had orthodontic treatment (tooth straightening)?

Please check "yes" or "no" to indicate if you have had any of the following:

Bad Breath Bleeding gums Blisters on lips or mouth Chew on one side of the mouth Clicking or popping jaw (TMJ) Dry mouth Food collection between the teeth Grind or brux your teeth Gums swollen or tender Jaw pain or tiredness Lip or cheek biting Loose teeth or broken fillings Mouth breathing Mouth pain Pain or ringing in/around the ear Periodontal treatment Sensitivity to cold Sensitivity to heat Sensitivity to sweets Sensitivity when biting Snoring Sores or growths in mouth

MEDICAL HISTORY

Medical Dr's Name _____ Phone (____) _____ Date of last visit _____

Please check "yes" or "no" to indicate if you have had any of the following:

- | | | | | | |
|---------------------------|--|-----------------------|--|-------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy/seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Thirst | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores/Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drug Addiction | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss,unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Women: Are you Pregnant? Yes No

Have you ever been hospitalized or do you have any other health concerns not listed? Yes No If yes, please explain:

Have you ever smoked or used tobacco? Yes No If yes, how long? _____

DRUG ALLERGIES:

Reviewing Doctor

MEDICATIONS:

Please list medications you are currently taking

Date

B.P.

SIGNATURE & AUTHORIZATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I hereby authorize payment directly to Dr. Hodges' office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Dr. Hodges' office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Signature of Patient, Parent, Guardian, or Personal Representative

Date

Please print the name of Patient, Parent, Guardian or Personal Rep.

Relationship to Patient