Patient History Form

Date_____ SS#_____

Patient

Name_____ Date of Birth_____
Last First Middle

Address_____Phone_____
No & Street City State & Zip

E-Mail Address:_____

Responsible Party (Please complete if patient is under 18 yrs old) Marital status: M_____ S_____

Name_____Relationship_____
Last First Middle

Address_____SS#_____Phone_____
No & Street City State & Zip

Employer(s)

Responsible Party's employer_____Phone_____

Address_____May we contact you at work?_____
No & Street City State & Zip

Spouse's Employer_____Phone_____

Address_____May we contact you at work?_____
No & street City State & Zip

Insurance

Primary Insurance: Employer_____Ins. Co Name_____

Ins Phone #_____ID#_____Group/Policy#_____

Secondary Insurance: Employer_____Ins. Co Name_____

Ins. Phone #_____ID#_____Group/Policy#_____

Emergency Contact

Name_____Phone_____Relationship_____

Referred by:

Patient/if so, who?_____SWBY Pages_____Walkin_____Internet_____
Yellowbook_____

Credit Card Authorization

I authorize the balance of my account to be charged to the following credit card if not paid in full within 60 days after services are complete.

MC #_____Exp. Date_____Amex #_____Exp. Date_____

Visa #_____Exp. Date_____Discover #_____Exp. Date_____

Please answer each question

1. Have you been a patient in the hospital in the past two years? Yes_____ No_____

2. Have you taken any kind of medicine or drugs in the past year for a medical condition? If Yes, What medications. Yes_____ No_____

3. Has anyone in your family been advised of difficulties during anesthesia? Yes_____ No_____

4. Are you allergic to penicillin or any other drug or medication? Yes_____ No_____
   Please List:_____
   _____

5. Have you ever had excessive bleeding requiring special treatment? Yes_____ No_____
   Please explain:_____

   Have you ever had TMJ (jaw joint) problems? Yes_____ No_____

6. Have you ever been pre-medicated with antibiotics prior to dental treatment for a medical condition? Yes_____ No_____

7. Circle any of the following which you have had or currently have:

heart trouble	asthma	stroke	daily aspirin
congenital heart lesions	cough	epilepsy	blood thinners
cardiac pacemaker	diabetes	psychiatric treatment	sickle cell anemia
heart murmur	tuberculosis	sinus trouble	joint replacement
high blood pressure	arthritis	cancer treatment	migraines
anemia	jaundice	AIDS/HIV+	osteoporosis
rheumatic fever	hepatitis	latex allergy	crohn's disease

8. In general (on a scale of 1-10), how anxious or uncomfortable are you about receiving dental treatment (1= not at all, 10= extremely)? _____

   Would you like to be sedated for your dental treatment? Yes_____ No_____

9. Have you ever had any other serious illnesses? Yes_____ No_____

10. Would you like to have whiter teeth? Yes_____ No ____

11. Would you like to be contacted for your six month checkups? Yes_____ No_____

12. Physician's name?_____Phone #_____

Women only

13. Are you pregnant now? Yes_____ No_____

14. Are you nursing? Yes_____ No_____

Chief dental complaint:

_____ _____
Patient/Guardian signature Date