After Hours Dentistry • Patient History Form

Patients First Name _____ **MI** ____ **Last Name** _____

ABOUT YOU

◯ Female ◯ Male

Todays date _____

E-mail address _____

I Prefer to be called _____

Birth date _____ Age ____ SS# _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Phone-Home _____ Cell _____

Work phone _____ Ext.# _____

Employer _____

Address _____

Occupation _____

Where and when best times to reach you? _____

_____

Referred by _____

Other family members seen by us _____

Google ☐ Yelp ☐ Social Media ☐ Website ☐

ABOUT SPOUSE

Name-First _____ Last _____

Birth date _____ Age ____ SS# _____

Phone-Home _____ Cell _____

Phone-Work _____ Ext.# _____

Employer _____

WHO IS RESPONSIBLE FOR YOUR ACCOUNT

Name-First _____ Last _____

Relation _____

SS# _____ Driver's license # _____

Work phone _____ Ext.# _____

Cell phone _____

Employer _____

WHO SHOULD WE CONTACT IN AN EMERGENCY?

Name-First _____ Last _____

Relationship _____

Phone-Home _____ Cell _____

PRIMARY INSURANCE COVERAGE

Dental coverage? ◯ Yes ◯ No

Insurance name _____

Insurance address _____

_____

Insurance phone _____

Group #, plan, local or policy #

_____

Insureds name _____

Insureds relation to patient _____

Insureds birth date _____

Insureds subscriber ID _____

Insureds employer _____

_____

YOUR MEDICAL CARE

Do you have a personal physician?

◯ Yes ◯ No

Physician's name _____

Physician's phone _____

Date of last visit _____

Are you currently under the care of a physician? ◯ Yes ◯ No

If yes, please explain _____

_____

_____

Your current physical health is:

◯ Good ◯ Fair ◯ Poor

Patients First Name _____ MI ____ Last Name _____

WHY HAVE YOU COME TO THE DENTIST TODAY?

List reasons here: _____

HEALTH INFORMATION

Have you ever taken Fosamax, Actonel, Boniva, or any other biphosphonate? ◯ Yes ◉ No

Do you take prescription, over-the-counter, or any drugs including b? Yes ◯ No ◉

If YES, list each one: _____

FOR WOMEN

◉ Yes ◯ No Are you using a prescribed birth control method?

◯ Yes ◯ No Are you pregnant?

◯ Yes ◯ No Are you nursing?

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

◯ Yes ◯ No Abnormal Bleeding
◯ Yes ◯ No Alcohol/Drug Abuse
◯ Yes ◯ No Anemia/Breathing Problems
◯ Yes ◯ No Arthritis / Rheumatism / Gout?
◯ Yes ◯ No Artificial Bones, Joints, Valves
◯ Yes ◯ No Asthma
◯ Yes ◯ No Blood Transfusion/Disease
◯ Yes ◯ No Cancer, Chemotherapy
◯ Yes ◯ No Congenital Heart Defect
◯ Yes ◯ No Diabetes
◯ Yes ◯ No Difficulty Breathing
◯ Yes ◯ No Emphysema
◯ Yes ◯ No Epilepsy
◯ Yes ◯ No Fainting/Dizziness
◯ Yes ◯ No Frequent Headaches
◯ Yes ◯ No Glaucoma
◯ Yes ◯ No Hay Fever
◯ Yes ◯ No Heart Problems
◯ Yes ◯ No Hepatitis
◯ Yes ◯ No Herpes, Fever Blisters
◯ Yes ◯ No High Blood Pressure
◯ Yes ◯ No HIV positive, AIDS
◯ Yes ◯ No Hospitalized for Any Reason
◯ Yes ◯ No Kidney Problems
◯ Yes ◯ No Liver Disease
◯ Yes ◯ No Low Blood Pressure
◯ Yes ◯ No Mitral Valve Prolapse
◯ Yes ◯ No Pacemaker
◯ Yes ◯ No Psychiatric Problems
◯ Yes ◯ No Radiation Treatments
◯ Yes ◯ No Seizures
◯ Yes ◯ No Shingles
◯ Yes ◯ No Sinus Problems
◯ Yes ◯ No Stroke
◯ Yes ◯ No Thyroid Problems
◯ Yes ◯ No Tuberculosis (TB)
◯ Yes ◯ No Ulcers

List any other serious medical conditions that you have ever had: _____

Patients First Name _____ MI ____ Last Name _____

SLEEP

◯ Yes ◯ No Do you snore while sleeping
◯ Yes ◯ No Have you been diagnosed/treated for sleep apnea?
◯ Yes ◯ No Do you use a CPAP or other appliance?

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

◯ Yes ◯ No Aspirin
◯ Yes ◯ No Codeine
◯ Yes ◯ No Dental Anesthetics
◯ Yes ◯ No Erythromycin
◯ Yes ◯ No Latex
◯ Yes ◯ No Penicillin
◯ Yes ◯ No Sulfa
◯ Yes ◯ No Tetracycline

List any other drugs or materials that you are allergic to: _____

◯ Yes ◯ No Have you ever had a serious or difficult problem associated with previous dental work?
◯ Yes ◯ No Do you require antibiotics before dental treatment?
◯ Yes ◯ No Are you currently in pain?
◯ Yes ◯ No Bleeding, Red, Swollen Gums?
◯ Yes ◯ No Clicking or popping jaw?
◯ Yes ◯ No Bad Breath?
◯ Yes ◯ No Do you smoke or use tobacco?
◯ Yes ◯ No Broken/Loose teeth of fillings?
◯ Yes ◯ No Grinding Teeth?
◯ Yes ◯ No Sores/Blisters in or around Mouth?

Additional comments: _____

CONSENT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Payment is due at time of service unless prior arrangements have been made. I understand that I am responsible for payment of services rendered and also responsible of any copay and deductibles that my insurance does not cover.

Signature _____ Date _____