Patient Information

Name:_____ Soc, Sec#_____
Last Name *First Name* *Intial*

Adress_____

City_____ State_____ Zip _____ Phone_____

Sex M F Age____ Birthdate_____ Single Married Separated Divorced

Patient Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Whom may we thank for referring you?_____

Notify in case of emergency_____ Phone_____

Primary Insurance

Person Responsible for the Account_____
Last Name *First Name* *Intial*

Relation to Patient _____ Birthdate_____ Soc. Sec#_____

Address if different from the patient _____ Phone_____

City_____ State_____ Zip_____

Person Responsible Employed By_____ Occupation_____

Business Address_____ Business Phone_____

Insurance Company_____

Contract#_____ Group#_____ Subscriber #_____

Name of other dependents under this plan_____

PATIENT HEALTH REGISTRATION Date_____

Name_____ Spouse's Name_____

Address_____

Home Phone_____ Business Phone_____

Cell Phone_____ Email Address_____

Date of Birth_____ Sex_____ Height_____ Weight_____

Social Security No._____ Single_____ Married_____

Employer_____ Occupation_____

Closest Relative_____ Phone_____

Whom may we thank for referring you to us?_____

MEDICAL HEALTH

Name and address of physician_____

Have you been under a physician's care during the past 2 years?___ For_____

Have you been treated in a hospital in the past 2 years?_____ For_____

Have you ever had a major surgery?_____

If female: Are you taking hormones or birth control?_____ Are you pregnant or nursing?____

Have you ever had a blood test for hepatitis?_____ Were you vaccinated?_____

Are you now taking or have taken any prescription drugs during the past year?_____

Please list: 1._____ 2._____ 3._____

4._____ 5._____ 6._____

Are you allergic to: ❑ Penicillin ❑ Codeine ❑ Local anesthetics Other_____

Have you had or do you now have:

	yes	no		yes	no
AIDS	❑	❑	Herpes	❑	❑
Abnormal blood pressure	❑	❑	High cholesterol	❑	❑
Allergies	❑	❑	Jaundice	❑	❑
Anemia	❑	❑	Kidney disease	❑	❑
Angina	❑	❑	Liver disease	❑	❑
Arthritis	❑	❑	Mitral Valve Prolapse	❑	❑
Artificial heart valves	❑	❑	Organ transplant	❑	❑
Artificial joints	❑	❑	Pacemaker	❑	❑
Asthma	❑	❑	Polio	❑	❑
Cancer	❑	❑	Prolonged bleeding	❑	❑
Chemotherapy	❑	❑	Prolonged cough	❑	❑
Congenital heart lesions	❑	❑	Psychiatric treatment	❑	❑
Diabetes	❑	❑	Radiation therapy	❑	❑
Drug dependency	❑	❑	Sickle cell anemia	❑	❑
Epilepsy	❑	❑	Stroke	❑	❑
Fainting	❑	❑	Thyroid disease	❑	❑
Glaucoma	❑	❑	Tuberculosis	❑	❑
Heart disease	❑	❑	Ulcers	❑	❑
Heart Murmur	❑	❑	Venereal disease	❑	❑

Have you any disease, condition, or problem not previously listed?_____

Additional Insurance

Is patient covered by additional insurance? Yes No

Subscriber Name_____ Relation to Patient _____Birthdate_____

Address if different from the patient _____ Phone_____

City_____ State_____ Zip_____

Subscriber Employed By_____ Occupation_____

Business Address_____ Business Phone_____

Insurance Company_____

Contract#_____ Group#_____ Subscriber #_____

Name of other dependents under this plan_____

DENTAL HEALTH

When was your last dental visit?_____
How often do you see your dentist?_____
Are you having any dental problems that require immediate attention?_____
Do any of the following cause tooth discomfort? Hot_____Cold_____Sweets_____Chewing_____
How often do you brush your teeth?_____Floss?_____
Do your gums bleed while cleaning?_____
Do your gums ever feel tender or swollen?_____
Have you had periodontal treatment?_____When?_____
Do you clench or grind your teeth?_____
Can you chew on both sides of your mouth?_____ Comfortably?_____
Do you have frequent headaches?_____ Earaches?_____
Have you ever had orthodontic treatment (braces)?_____When?_____
Do you lose fillings or break fillings?_____
Do you usually have many cavities?_____
Do you have any loose teeth?_____ Cracked or broken teeth?_____
Do you have any noticeable wear on your teeth?_____ Food traps?_____
Do you have any missing teeth?_____ Have they ever been replaced?_____
If so, how? Fixed bridge_____ Removable partial_____ Full denture_____ Dental implant_____
Are you comfortable with the replacement?_____ Please describe_____

TMJ History :
Have you ever had a problem with your TMJ's (your jaw joints)?_____
Have you ever had an injury to your jaw?_____
Do your jaw joints ever hurt or become tender when you chew or talk?____ Or open wide?____
Do you ever hear any clicks, pops, or grating sounds in your jaw joints?_____
Does your jaw ever get stuck, or locked or go out?_____
Do you ever have difficulty opening your jaw?_____When does it happen?_____
Do you ever have any problems with your joints when you eat or chew?_____
Does your jaw ever feel tired or ache?_____

Aesthetics:
How do you feel about the appearance of your smile?_____
Would you like whiter teeth?_____
Have you ever had any cosmetic dentistry done to improve your appearance?_____
If yes, are you pleased with the result?_____Please comment_____

Have you ever had an unpleasant dental experience?_____
Please add anything you feel is important:_____

Informed consent: I consent to receive special consultation and should I agree to accept professional advice, also consent to the performing of whatever dental procedure may be decided necessary or advisable in the opinion of Dr. Soria. I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, at or before completion, unless other specific arrangements are made with the office manager. I authorize my insurance carrier to issue the dental benefits of my plan directly to this dental office. I also authorize release of any information necessary to process dental insurance.

Medical History

Patient Name_____

Although dental personal 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 interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now Yes No N/A _____

Have you ever been hospitalized or had a major operation? Yes No N/A _____

Have you ever had a serious head or neck injury Yes No N/A _____

Are you taking any medications, pills, or drugs? Yes No N/A _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No N/A _____

Are you on a special diet? Yes No N/A _____

Do you use tobacco? Yes No N/A _____

Do you use controlled substance? Yes No N/A _____

Women: Are you Pregnant / Trying to get pregnant? Nursing?
Taking oral contraceptives?

Are you allergic to any of the following?
Asprin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
Other _____

Do you have, or have you had, any of the following?
AIDS/ HIV Positive
Alzheimer's Disease
Anaphylaxis
Anemia
Angina
Arthritis/ Gout
Artificial Heart Value
Artificial Joint
Asthma
Blood Disease
Blood Transfusion
Breathing Problems
Bruise Easily

Cancer
Chemotherapy
Cold Sores/ Fever Blisters
Congenital Heart Disorder
Convulsions
Cortisone Medicine
Diabetes
Drug Addiction
Easily Winded
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spells/ Dizziness
Frequent Cough
Frequent Diarrhea
Frequent Headache
Genital Herpes
Glaucoma
Hay Fever
Heart Attack/ Failure
Heart Murmur*
Heart Pace Maker*
Heart Trouble/ Disease
Hemophilia
Hepatitis A
Hepatitis B or C
Herpes
High Blood Pressure
Hives or Rash
Hypoglycemia
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Pain in Jaw Joints
Parathyroid Disease
Psychiatric Care
Radiation Treatment
Recent Weight Loss
Renal Dialysis
Rheumatic Fever
Rheumatism

Scarlet Fever
Shingles
Sickle Cell Disease
Sinus Trouble
Spina Bifida
Stomach/ Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease
Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No
NA_____

Comments_____
_____
_____

*Condition may require medication. N/A not answered my patient

To the best of my knowledge, the questions on the 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 nay changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

These are things that are important to me about my Dental Health

CIRCLE ONE

My mouth is	A) very comfortable B) moderately comfortable C) uncomfortable
I I am	A) think the appearance of my mouth is excellent B) satisfied with the appearance of my mouth C) dissatisfied
I	A) will do anything to keep my natural teeth B) want to keep my teeth, but have a certain budget of time and money I am willing to spend on them C) don't care weather I keep my teeth or not
I	A) have a goal set for my oral health with a previous dentist B) want to set up goals concerning my dental health C) never set goal concerning my dental health
I	A) have always done the best that was recommended for my dental health B) have not done what dentist have recommended for my mouth C) rarely go, and don't care much about having my dental work completed
I have	A) put dentistry for myself and my family high on my priority list B) put dentistry for myself and my family low on my priority list \ C) it's on my list but hard to find
I think my present dental heath is	A) excellent

	B) good C) poor
I aspire to a mouth with:	A) excellent health B) good health C) poor health

What are some questions about dentistry and oral health that you have never had adequately answered for you?