Patient Information Form

Today's Date _____

Patient's Name First _____ MI ____ Last _____ Nickname _____

Address Street _____ City _____ State _____ Zip _____

Phone Primary _____ Mobile _____ Work _____

Date of Birth _____ **Social Security Number** _____

Drivers License # _____ State _____

Patient Employed By _____ Phone _____

Address Street _____ City _____ State _____ Zip _____

Sex ☐Male ☐Female **Marital Status** ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

In case of emergencies, who should be notified? _____

Relationship to Patient _____ Primary Phone _____

Is patient a minor ☐Yes ☐No **Full Time Student** ☐Yes ☐No Name of School _____

Name of Responsible Party First _____ Last _____

Date of Birth _____ Relationship to Patient ☐Spouse ☐Parent ☐Other: _____

If Patient is a Minor, primary residence: ☐Both parents ☐Mom ☐Dad ☐Shared Custody ☐Guardian ☐Other: _____

Address *(if different from patient)* Street _____ City _____ State _____ Zip _____

Phone Primary _____ Mobile _____ Work _____

Employer *(if different from above)* _____ Phone _____

Address Street _____ City _____ State _____ Zip _____

☐ **Text message** – best number to text you: _____

☐ **Email** – please provide your email address: _____

Primary Dental Plan Name _____ **Phone** _____

Address Street _____ City _____ State _____ Zip _____

Name of Insured _____ **Date of Birth** _____ ID # _____

Policy Number _____ **Patient Relationship to Insured** _____

Secondary Dental Plan Name _____ **Phone** _____

Address Street _____ City _____ State _____ Zip _____

Name of Insured _____ **Date of Birth** _____ ID # _____

Policy Number _____ **Patient Relationship to Insured** _____

How did you hear about us?

☐One of our valued patients (name of patient) _____

☐Facebook ☐Our Website

☐Phonebook ☐Internet Search

☐Our Location ☐Other: _____

Time 2:38 PM

Arrow Dental Center

Eaglesoft Medical History

Date 5/11/2016

Patient Name: Birth Date: Date Created:

Although dental personnel 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	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

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

Signature of Patient, Parent or Guardian:

X

Date:_____

Dental History Form

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

Date of last radiographs (xrays) and exam _____

Date of last hygiene continuing care appointment *(cleaning or periodontal maintenance)* _____

Former Dentist _____ Phone _____

If you left your previous dentist, what are the reasons? _____

Have you had problems with prior dental treatment? ☐Yes ☐No

If yes, what were they? _____

Are you experiencing any pain now? ☐Yes ☐No

If yes, please describe _____

Have you ever been pre-medicated for dental treatment? ☐Yes ☐No

If yes, why? _____

Have you been anxious about having dental treatment? ☐Yes ☐No

If yes, would you be comfortable sharing why? _____

Would you like to discuss this concern with the doctor to learn about your relaxation options? ☐Yes ☐No

What concerns do you currently have with your oral health or smile? *(please check all that apply)*

☐Jaw joint pain
☐Clenching or grinding of teeth
☐Discolored teeth
☐Crowding/crooked teeth
☐Missing teeth
☐Spaces in between teeth
☐Loose tooth/teeth
☐Tooth shape/size
☐Unhappy with appearance of teeth
☐Overbite
☐Underbite
☐Uncomfortable bite
☐Old fillings *(gold or silver)*
☐Old crowns
☐Speech problems
☐Too much gum tissue when I smile
☐Tooth sensitivity to hot/cold
☐Tooth sensitivity to biting
☐Tooth sensitivity to sweets
☐Food gets caught between teeth
☐Difficulty chewing
☐Bad breath
☐Other: _____

Have you ever had orthodontic treatment? ☐Yes ☐No If yes, when? _____

Have you ever had periodontal treatment such as deep cleanings, root planning, or periodontal surgery? ☐Yes ☐No

If yes, what kind of treatment and when? _____

Are you interested in learning about the following? *(please check all that apply)*

☐Teeth Whitening
☐Orthodontic treatment
☐Tooth replacement options
☐Botox for clenching and grinding
☐Tooth colored fillings
☐Dental implants
☐oral hygiene care for infants/toddlers
☐Cosmetic Botox
☐At home oral hygiene care
☐Periodontal prevention/treatment
☐Juvederm filler around mouth
☐Other: _____