Confidential Patient Information Form

PATIENT

Date____________

Patient's Last name ______________________________ First name ______________________________ Middle initial _______________

Title ▢Mr. ▢Mrs. ▢Ms. ▢Miss ▢Dr. ▢Other ________ I prefer to be called ________________________________

Birth date _______________ Sex: Male ▢ Female ▢ Social Security # ________ - ____ - ________

Marital Status ▢ Single ▢ Married ▢ Separated ▢ Divorced ▢ Widowed

Home address ______________________________________ City ____________________ State _______ Zip code ________________

Home phone (______)________________ Cell phone (______)________________ Work phone (______)_________________________

E-mail address(es) ____

Occupation ____ Employer ____

CLOSEST RELATIVE

Spouse or closest relatives name(s) ____

Title ▢Mr. ▢Mrs. ▢Ms. ▢Miss ▢Dr. ▢Other ________ Relationship to patient ______________________________

Address (*if different than patient address*) ____

Home phone (______)________________ Cell phone (______)________________ Work phone (______)_________________________

PREVIOUS DENTIST

Previous Dentist ____________________________ Address____

Last seen _______________________ Reason____

Other dentists/dental specialists now being seen: Name _________________________ City __________________ State ____________

Reason ____

PHYSICIAN

Patient's Physician _____________________________ Address____

Last seen _______________________ Reason _______________________ Next appointment ________________________________

Most recent physical exam ____

Other physicians/health care providers being seen now:

Name ____City _________________________________ State ____________________

Reason ____

Name ____City _________________________________ State ____________________

Reason ____

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GENERAL INFORMATION

What concerns you about your teeth?____

Who suggested that you might need dental treatment? ____

Why did you select our office? ____

Have you had any previous dental treatment? Please describe ____

Have any other family members been treated in this office? Please name them. ____________________________________

Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain. _________________________

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? ____

Address (*if different than patient address)* ____

Home phone (______)________________ Cell phone (______)________________ E-mail address(es) ___________________________

Social Security # ________ - ____ - ________ Employer: ____

Who will be responsible for bringing the patient to dental appointments? ____

DENTAL INSURANCE

Primary policy holder's full name ____ Birthdate ___________________

Social Security # ________ - ____ - ________ Relationship to patient ____

Address and phone (if not listed above) ____

Employer ____ Address ____

Insurance company ____ Group # _______________ ID# ___________________________

Does this policy have dental/orthodontic benefits? ☐ Yes ☐ No ☐ Don't know

Secondary policy holder's full name ____ Birthdate _________________

Social Security # ________ - ____ - ________ Relationship to patient ____

Address and phone (if not listed above) ____

Employer ____ Address ____

Insurance company ____ Group # _______________ ID# ___________________________

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Your answers are for office records only, and are confidential. A thorough medical/dental history is essential to providing a comprehensive dental evaluation. *For the following questions mark yes, no, or don't know/understand (dk/u).*

MEDICAL HISTORY

Now or in the past, have you had:

▢**yes** ▢**no** ▢**dk/u** Birth defects or hereditary problems?
▢**yes** ▢**no** ▢**dk/u** Bone fractures, or major injuries?
▢**yes** ▢**no** ▢**dk/u** Any injuries to face, head, neck?
▢**yes** ▢**no** ▢**dk/u** Arthritis or joint problems?
▢**yes** ▢**no** ▢**dk/u** Endocrine or thyroid problems?
▢**yes** ▢**no** ▢**dk/u** Diabetes or low sugar?
▢**yes** ▢**no** ▢**dk/u** Kidney problems?
▢**yes** ▢**no** ▢**dk/u** Cancer, tumor, radiation treatment or chemotherapy?
▢**yes** ▢**no** ▢**dk/u** Stomach ulcer, hyperacidity, acid reflux?
▢**yes** ▢**no** ▢**dk/u** Immune system problems?
▢**yes** ▢**no** ▢**dk/u** History of osteoporosis?
▢**yes** ▢**no** ▢**dk/u** Gonorrhea, syphilis, herpes, STD's?
▢**yes** ▢**no** ▢**dk/u** AIDS or HIV positive?
▢**yes** ▢**no** ▢**dk/u** Hepatitis, jaundice or other liver problem?
▢**yes** ▢**no** ▢**dk/u** Polio, mononucleosis, tuberculosis, pneumonia?
▢**yes** ▢**no** ▢**dk/u** Seizures, fainting spells, neurologic problem?
▢**yes** ▢**no** ▢**dk/u** Mental health disturbance or depression?
▢**yes** ▢**no** ▢**dk/u** Vision, hearing, or speech problems?
▢**yes** ▢**no** ▢**dk/u** History of eating disorder (anorexia, bulimia)?
▢**yes** ▢**no** ▢**dk/u** High or low blood pressure?
▢**yes** ▢**no** ▢**dk/u** Excessive bleeding or bruising, anemia?
▢**yes** ▢**no** ▢**dk/u** Chest pain, short of breath, tire easily, swollen ankles?
▢**yes** ▢**no** ▢**dk/u** Heart defects, heart murmur, rheumatic heart disease?
▢**yes** ▢**no** ▢**dk/u** Angina, arteriosclerosis, stroke or heart attack?
▢**yes** ▢**no** ▢**dk/u** Skin disorder (other than common acne)?
▢**yes** ▢**no** ▢**dk/u** Do you eat a well balanced diet?
▢**yes** ▢**no** ▢**dk/u** Frequent headaches or migraines?
▢**yes** ▢**no** ▢**dk/u** Frequent ear infections, colds, throat infections?
▢**yes** ▢**no** ▢**dk/u** Asthma, sinus problems, hayfever?
▢**yes** ▢**no** ▢**dk/u** Tonsil or adenoid condition?
▢**yes** ▢**no** ▢**dk/u** Do you frequently breathe through your mouth?
▢**yes** ▢**no** ▢**dk/u** Joint replacement surgery?
▢**yes** ▢**no** ▢**dk/u** Heart Surgeries (valves, coronary bypass, stents)

Have you had allergies or reactions to any of the following:

▢**yes** ▢**no** ▢**dk/u** Local anesthetics (Novocain, lidocaine, xylocain)
▢**yes** ▢**no** ▢**dk/u** Latex (gloves, balloons)
▢**yes** ▢**no** ▢**dk/u** Aspirin
▢**yes** ▢**no** ▢**dk/u** Ibuprofen (Motrin, Advil)
▢**yes** ▢**no** ▢**dk/u** Penicillin
▢**yes** ▢**no** ▢**dk/u** Other antibiotics
▢**yes** ▢**no** ▢**dk/u** Metal (jewelry, clothing snaps)
▢**yes** ▢**no** ▢**dk/u** Acrylics
▢**yes** ▢**no** ▢**dk/u** Plant pollens
▢**yes** ▢**no** ▢**dk/u** Animals
▢**yes** ▢**no** ▢**dk/u** Foods
▢**yes** ▢**no** ▢**dk/u** Other substances ______________________

DENTAL HISTORY

Now or in the past, have you had:

▢**yes** ▢**no** ▢**dk/u** Permanent or extra (supernumerary) teeth removed?
▢**yes** ▢**no** ▢**dk/u** Supernumerary (extra) or congenitally missing teeth?
▢**yes** ▢**no** ▢**dk/u** Chipped or injured primary or permanent teeth?
▢**yes** ▢**no** ▢**dk/u** Any sensitive or sore teeth?
▢**yes** ▢**no** ▢**dk/u** Bleeding gums, bad taste or mouth odor?
▢**yes** ▢**no** ▢**dk/u** Jaw fractures, cysts, infections?
▢**yes** ▢**no** ▢**dk/u** Any teeth treated with root canals or pulpotomies?
▢**yes** ▢**no** ▢**dk/u** "Gum boils," frequent canker sores or cold sores?
▢**yes** ▢**no** ▢**dk/u** History of speech problems or speech therapy?
▢**yes** ▢**no** ▢**dk/u** Difficulty breathing through nose?
▢**yes** ▢**no** ▢**dk/u** Food impaction between the teeth?
▢**yes** ▢**no** ▢**dk/u** Mouth breathing habit or snoring at night?
▢**yes** ▢**no** ▢**dk/u** History of speech problems?
▢**yes** ▢**no** ▢**dk/u** Frequent oral habits (sucking finger, chewing pens, etc.)?
▢**yes** ▢**no** ▢**dk/u** Teeth causing irritation to lip, cheek or gums?
▢**yes** ▢**no** ▢**dk/u** Abnormal swallowing (tongue thrust)?
▢**yes** ▢**no** ▢**dk/u** Tooth grinding or clenching?
▢**yes** ▢**no** ▢**dk/u** Clicking, locking in jaw joints?
▢**yes** ▢**no** ▢**dk/u** Soreness in jaw muscles or face muscles?
▢**yes** ▢**no** ▢**dk/u** Ringing in ears, difficulty in chewing or opening jaw?
▢**yes** ▢**no** ▢**dk/u** Have you ever been treated for "TMJ" or "TMD" problems?
▢**yes** ▢**no** ▢**dk/u** Any broken or missing fillings?
▢**yes** ▢**no** ▢**dk/u** Any serious trouble associate with previous dental treatment?
▢**yes** ▢**no** ▢**dk/u** Have you ever been diagnosed with gum disease?
▢**yes** ▢**no** ▢**dk/u** Have you ever had an orthodontic consultation or treatment before?

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PATIENT HEALTH INFORMATION

List all medication, nutritional supplements, herbal medication and/or non-prescription medicines, including fluoride supplements that you currently take.

Medication ____ Taken for ____

Medication ____ Taken for ____

Medication ____ Taken for ____

Have you ever taken any medications to strengthen your bones? Please describe. ____

Do you or have you ever had a substance abuse problem? ____

Do you chew or smoke tobacco? ____

Have you noticed any changes in your face or jaws? ____

Any other physical problems? ____

How often do you brush? ____

How often do you floss? ____

Women: Are you pregnant? ☐ Yes ☐ No Are you trying to become pregnant? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders ____

Diabetes ____

Arthritis ____

Severe allergies ____

Unusual dental problems ____

Jaw size imbalance ____

Other family medical conditions? ____

RELEASE AND WAIVER

I authorize release of any information regarding my dental treatment to my dental and/or medical insurance company.

Signature ____ Date ___________________________

I have read the above questions and understand them completely. I will not hold Dr. Nancy Block DDS or any staff member responsible for any errors or omissions that I have made in the completion of this form. I will immediately notify Dr. Nancy Block DDS of any changes in my medical or dental health.

Signature ____ Date ___________________________