

Welcome

Please fill out this patient information form giving particular attention to the dental and medical health sections. Dr. Gordon will go over these sections with you. A clear understanding of your personal health profile insures safe, appropriate treatment.

PATIENT INFORMATION

DATE \_\_\_\_\_

Mr. Mrs. Ms. Dr. \_\_\_\_\_

PATIENT'S LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

How would you prefer to be contacted? \_\_\_ phone \_\_\_ email \_\_\_ text

SOCIAL SECURITY NUMBER \_\_\_\_\_ AGE \_\_\_\_\_

DENTAL HISTORY

CHIEF ORAL COMPLAINT OR REASON FOR TODAY'S VISIT \_\_\_\_\_

DATE OF LAST DENTAL EXAM \_\_\_\_\_ ANY PREVIOUS MAJOR DENTAL TREATMENT  YES  NO WHEN \_\_\_\_\_

WHEN WAS YOUR LAST FULL MOUTH X-RAY TAKEN? \_\_\_\_\_ WHEN WAS YOUR LAST CLEANING? \_\_\_\_\_

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING: - INDICATE WITH A (✓)

- Teeth sensitive to cold, heat, sweets or pressure
Bleeding gums.
Burning of tongue
Swelling or lumps in mouth
Frequent blisters on lips or mouth
Pain around ear
Unusual sounds in ear while eating
Bad breath
Unpleasant taste
Unfavorable dental experience
Complications from extractions
Periodontal treatment
Orthodontic treatment
Mouth breathing
Oral habits, i.e., finger nail biting, cheek biting, etc.
Cigarettes, pipe or cigar smoking, chewing tobacco
Texture of toothbrush, Soft/Med/Hard
Frequency of brushing
Dental Floss
Inter dental stimulators
Water jet device
Disclosing tablets or solution
Fluoride supplements

MEDICAL HISTORY

PHYSICIAN \_\_\_\_\_ ADDRESS \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

ARE YOU IN GOOD HEALTH? \_\_\_\_\_ IF NO, EXPLAIN \_\_\_\_\_

DO YOU HAVE ANY EXISTING ILLNESS? \_\_\_\_\_ IF YES, EXPLAIN \_\_\_\_\_

HAVE YOU BEEN HOSPITALIZED IN THE PAST TWO YEARS? \_\_\_\_\_ IF YES, EXPLAIN \_\_\_\_\_

DO YOU BLEED EXCESSIVELY WHEN CUT? \_\_\_\_\_ DO YOU SMOKE? \_\_\_\_\_ IF YES, HOW MUCH \_\_\_\_\_

ARE YOU TAKING ANY MEDICATION, PILLS OR DRUGS? \_\_\_\_\_ IF SO, PLEASE LIST \_\_\_\_\_

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- Heart disease
High blood pressure
Blood or AIDS related disease
Rheumatic fever
Heart murmur
Diabetes
Stroke
Epilepsy or seizures
Arthritis
Tumor history/cancer
Radiation treatment
Liver disease or Hepatitis
Kidney disease
Sinus problems
Asthma
Sleep apnea
CPAP machine
Headaches, stress or migraines
Osteoporosis
Joint replacement
Bisphosphonates
Aredia I.V., Reclast I.V.
Zometa I.V.
Fosamax, Actinel, Boniva
Allergy to:
latex
pain medication
penicillin
other antibiotics
local anesthetics
other
Are you pregnant? \_\_\_\_\_

IF YES, TO ANY OF THE QUESTIONS ABOVE. PLEASE EXPLAIN \_\_\_\_\_

FINANCIAL

This dental office does not participate with any insurance companies. We will submit insurance and/or pre-authorization forms for your insurance to reimburse you directly. Payment is due at time of service.

PERSON FINANCIAL RESPONSIBLE FOR ACCOUNT \_\_\_\_\_ RELATIONSHIP TO YOU \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_ BUSINESS ADDRESS \_\_\_\_\_

DENTAL INSURANCE \_\_\_\_\_ MEMBER ID \_\_\_\_\_ GROUP # \_\_\_\_\_

I AGREE TO ASSUME FULL FINANCIAL RESPONSIBILITY FOR ALL TREATMENT RENDERED.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_