PATIENT INFORMATION FORM

Today's Date:____________________

Name:____________________

Address:____________________

City:__________ State:___ Zip:__________

Home Phone:____________________

Cell:____________________

E-mail:____________________

Preferred method of contact: (please check all that apply)

E-mail____ Home phone____ Cell phone____

Birth date:__________ Age:__________

Married___ Single___ Divorced___ Widowed___

DENTAL INSURANCE

Primary Insurance Company:____________________

Subscriber Name:____________________

Subscriber's Birthdate:____________________

Subscriber's ID/SSN:____________________

Secondary Insurance Company:____________________

Subscriber Name:____________________

Subscriber's Birthdate:____________________

Subscriber's ID/SSN:____________________

ACCOUNT INFORMATION

Person responsible for account: ____________________

PATIENT

Name: ____________________

Occupation: ____________________

Employer:____________________

Business Phone:____________________

SPOUSE/SIGNIFICANT OTHER

Name:____________________

GETTING TO KNOW YOU

Is another member of your family, or relative a patient at our office?____________________

Referred to us by: ____________________

Convenient appointment day/time:__________

Emergency Contact

Name:____________________

Relationship:____________________

Phone:____________________

DENTAL HISTORY

	YES	NO
Are you afraid of receiving dental care?	☐	☐
Are you happy with the appearance of your teeth?	☐	☐
Do you have any TMJ/Jaw problems?	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you have earaches or neck pains?	☐	☐
Are your teeth sensitive to hot/cold/sweet?	☐	☐
Do your gums bleed?	☐	☐
Have you ever had gum surgery?	☐	☐
Have you had deep cleaning/scaling/root planning?	☐	☐
Does food or floss catch between your teeth?	☐	☐
Have you ever had orthodontic treatment?	☐	☐

	YES	NO
Is your mouth dry?	☐	☐
Are you satisfied with previous dental care?	☐	☐
Have you had problems after dental treatment?	☐	☐

Previous Dentist's name:____________________

When was your last cleaning?____________________

When were your last x-rays?____________________

Please list any tobacco products that you have used

____

Do you have questions/concerns to discuss?____________________

____

Is there any other dental information we should know about?____________________

Do you have a dental problem now? ☐ ☐

If yes, please explain____________________

What is the reason for your visit today?____________________

MEDICAL HISTORY

The following information is essential for the safe and effective diagnosis and treatment of each patient.

Please check if you now have or ever had:

	Yes	No
Autoimmune disease (Lupus, Sjogren's, other)	☐	☐
Rheumatoid arthritis	☐	☐
Congenital heart disease	☐	☐
Heart Attack	☐	☐
Heart murmur	☐	☐
Rheumatic fever	☐	☐
Mitral valve prolapsed	☐	☐
Irregular heart beat	☐	☐
Angina/Chest pain	☐	☐
Heart surgery	☐	☐
Heart pace maker	☐	☐
Artificial heart valve	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐
Stroke	☐	☐
Anemia	☐	☐
Hemophilia/Bleeding/Bruise easily	☐	☐
AIDS/HIV positive//Immune Supression	☐	☐
Blood transfusion If yes, date:______________	☐	☐
Hepatitis A (infectious), B, C	☐	☐
Liver disease	☐	☐
Cancer/Chemo/Radiation If yes, type, dates:____________________	☐	☐

	Yes	No
Herpes	☐	☐
Diabetes (Type 1, Type 2)	☐	☐
Thyroid disease	☐	☐
Kidney disease/Dialysis	☐	☐
Ulcers	☐	☐
Epilepsy/Seizures	☐	☐
Drug/Alcohol Treatment/Dependency	☐	☐
Steroid treatment	☐	☐
Artificial Joints/Pins, Plates If yes, which joint, date:________________	☐	☐
Sinus problems	☐	☐
Mental health disorders	☐	☐
Osteoporosis	☐	☐
Glaucoma	☐	☐
Eating disorder	☐	☐
Gastrointestinal disease/Chrohn's Disease	☐	☐
Acid reflux/persistent heartburn	☐	☐
Tuberculosis	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Lung disease/Emphysema	☐	☐
Allergies to medications If yes,please list:____________________________	☐	☐

Do you have any disease, condition, or problem not listed above that you think I should know about?________________________

Are you taking or have you ever used in the past any Bisphosphonate drug such as Fosamax, Zometa, Didronel, Reclast, Aredia, Atelvia, or Skelid for Osteoporosis, Paget's Disease or Multiple Myeloma?

YES ☐ **NO** ☐ If yes, please list:________________________

Dates:____________________

WOMEN ONLY	**YES**	**NO**
Are you Pregnant?	☐	☐
If yes, number of weeks?______		
Nursing?	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐

List current medications (include all prescription, vitamins, over the counter or natural supplements):

To the best of my knowledge, the above questions have been accurately answered. If any changes in my health status or medication changes, I will inform the office. I understand, hereby authorize Dr. Bauer to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient needs. I also authorize Dr. Bauer to perform routine treatment that may be indicated and further authorize and consent that the doctor choose and employ such assistance as he deems fit. I understand the use of anesthetic agents embodies a certain risk. I understand that I may ask any and all questions I have at any time. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine. DUE AND PAYABLE AT THE TIME OF SERVICE UNLESS PRIOR FINANCIAL ARRANGEMENTS ARE MADE. I also understand a finance charge of 21% APR may be accessed on my outstanding balance over thirty days.

Date

Print patient Name

Patient Signature/ Parent or Guardian Signature