

# PERSONAL HISTORY

(ALL INFORMATION WILL BE HELD IN STRICT CONFIDENCE)

Date \_\_\_\_\_

Patient's Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ M/F \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Father's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ DOB \_\_\_\_\_

Home Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Father Employed By \_\_\_\_\_ Occupation \_\_\_\_\_ Bus. Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ DOB \_\_\_\_\_

Home Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Mother Employed By \_\_\_\_\_ Occupation \_\_\_\_\_ Bus. Phone \_\_\_\_\_

Have we seen any other family members? \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

## MEDICAL-DENTAL HISTORY

	YES	NO	DO NOT KNOW
Recent weight change			
High blood pressure			
Low blood pressure			
Blood diseases			
Shortness of breath			
Chest pain			
Epilepsy			
Tuberculosis			
Anemia			
Rheumatic fever			
Hepatitis			
Swelling of feet or ankles			
Asthma			
Fainting or dizziness			
Excessive thirst			
Frequent cough			
Pain in region of the ear			
Other ... What?			

What is your main problem? \_\_\_\_\_  
 How long has it troubled you? \_\_\_\_\_  
 Are you under a physician's care now? \_\_\_\_\_  
 For what? \_\_\_\_\_

What major operations have you had? \_\_\_\_\_

What drugs or medicines are you taking now? \_\_\_\_\_

What drugs, medicines or other things are you allergic to? \_\_\_\_\_

When was your last complete physical exam? \_\_\_\_\_

When was your last complete dental exam? \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Have you had any past complicated extractions? \_\_\_\_\_

Have you had radiation treatments? \_\_\_\_\_

Have you had prolonged bleeding when cut? \_\_\_\_\_

Do you have a heart pacer? \_\_\_\_\_

Do you wear contact lenses? \_\_\_\_\_

Women—are you pregnant? \_\_\_\_\_

Is there a history of or problem with:

Diabetes \_\_\_\_\_

Heart disease \_\_\_\_\_

Lung disease \_\_\_\_\_

Kidney disease \_\_\_\_\_

Liver disease \_\_\_\_\_

AIDS \_\_\_\_\_

	YES	NO	DO NOT KNOW
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 Asthma \_\_\_\_\_  
 Fainting or dizziness \_\_\_\_\_  
 Excessive thirst \_\_\_\_\_  
 Frequent cough \_\_\_\_\_  
 Pain in region of the ear \_\_\_\_\_  
 Other ... What? \_\_\_\_\_

Summary (Dr. use)



Signature of Patient (Parent or Guardian if Patient is minor)

Date \_\_\_\_\_

(over)

### DOCTOR'S NOTES

Person responsible for this professional fee \_\_\_\_\_

Mailing Address \_\_\_\_\_

How do you plan to pay for the professional fees?

Cash \_\_\_\_\_ Check \_\_\_\_\_

Other, please explain \_\_\_\_\_

If check, driver's license no. of person writing check \_\_\_\_\_

**DENTAL INSURANCE COVERAGE INFORMATION:**

1. Name of insured \_\_\_\_\_ Social Security # \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Policy# \_\_\_\_\_ Group# \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Other Dental Coverage? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Insured \_\_\_\_\_ Social Security # \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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