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**PATIENT INFORMATION FORM**

Date: \_\_\_\_\_ Referred By: \_\_\_\_\_ General Dentist: \_\_\_\_\_

**Patients Name** \_\_\_\_\_  Male  Female  
First Name Middle Name Last Name

Street Address: \_\_\_\_\_ PO Box/Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced

**HOME PHONE:** \_\_\_\_\_ **CELL PHONE:** \_\_\_\_\_

Birthdate: \_\_\_\_\_ Name of School (if student): \_\_\_\_\_

Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Drivers License Number: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Spouse Name:** \_\_\_\_\_ **If Minor** \_\_\_\_\_

Birth Date: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Business Address: \_\_\_\_\_ Birth date Mother: \_\_\_\_\_ Father: \_\_\_\_\_

\_\_\_\_\_ Employed By: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Business Address: \_\_\_\_\_

\_\_\_\_\_ Business Phone: \_\_\_\_\_

**In Case of Emergency**

Nearest relative or friend not living with you: \_\_\_\_\_ Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

**Person Responsible for Bill/Insured Name:** \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Dental Insurance: \_\_\_\_\_ Insured's Soc. Sec. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insured Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Group Number: \_\_\_\_\_ Insured Employer: \_\_\_\_\_

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**Do you have dual coverage?**     Yes     No

(If yes, please fill out the following)

Secondary Insured Name: \_\_\_\_\_ Dental Insurance: \_\_\_\_\_

Birth date: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insurance Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Group Number: \_\_\_\_\_ Insured Employer: \_\_\_\_\_

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## Confidential History Form

The Following questionnaire will provide important information to help us treat you properly. Your responses are confidential.

**Please read every question carefully.**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Referring Dentist/Physician: \_\_\_\_\_

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Your Physician's Name: \_\_\_\_\_ General Practice or Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Are you in good health?     Yes     No                      Date of last physical: \_\_\_\_\_

Has there been any change in your general health in the past year?     Yes     No                      Past 5 years?     Yes     No

If yes, dates and condition treated: \_\_\_\_\_

Have you been hospitalized or had a serious illness or operation?     Yes     No

If yes, please explain: \_\_\_\_\_

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## Illness/Disease History

Do you have or have you had any of the following diseases or problems? Please circle Yes or No

Osteoporosis/Osteopenia	Yes   No	Liver Disease	Yes   No	Pain in Jaw Joints	Yes   No
Heart Disease/Attack	Yes   No	Yellow Jaundice	Yes   No	Arthritis/Rheumatism	Yes   No
Chest Pain/Angina	Yes   No	Hepatitis A, B, or C	Yes   No	Stomach Ulcers	Yes   No
Arteriosclerosis	Yes   No	Blood Disease	Yes   No	Bleeding Disorder	Yes   No
High/Low Blood Pressure	Yes   No	Blood Transfusion	Yes   No	Anemia	Yes   No
Cong. Heart Lesions	Yes   No	Eating Disorder	Yes   No	Bruise Easily	Yes   No
Rheumatic Fever	Yes   No	Cough	Yes   No	Sickle Cell Disease	Yes   No
Scarlet Fever	Yes   No	Emphysema	Yes   No	Kidney Trouble	Yes   No
Heart Murmur	Yes   No	Tuberculosis (TB)	Yes   No	Diabetes /Type I or II	Yes   No
Artificial Heart Valve	Yes   No	Asthma/Bronchitis	Yes   No	Thyroid Disease	Yes   No
Mitral Valve Prolapse	Yes   No	Hay Fever	Yes   No	Glaucoma	Yes   No
Heart Pacemaker	Yes   No	Sinus Trouble	Yes   No	Psychiatric Treatment	Yes   No
Heart Surgery	Yes   No	Allergies/Hives	Yes   No	Nervousness	Yes   No
Artificial Joint	Yes   No	Cortisone Medication	Yes   No	Xray/Cobalt Treatment	Yes   No
Immune System Disorder	Yes   No	Stroke /TIA	Yes   No	Chemotherapy/Cancer	Yes   No
HIV or AIDS	Yes   No	Leukemia	Yes   No	Epilepsy or Seizures	Yes   No
Fainting/Dizzy Spells	Yes   No	Substance Abuse	Yes   No	Herpes	Yes   No
Alcoholism	Yes   No	Easily Winded	Yes   No	VD (Syphilis/Gonorrhea)	Yes   No

**If yes, please explain:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Allergy History

Are you allergic or have reacted adversely to any drugs or medication?  Yes  No

If yes, please check and or list below:

### Local Anesthetic:

- |                                                      |                                         |                                               |
|------------------------------------------------------|-----------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Aspirin                     | <input type="checkbox"/> Novocaine      | <input type="checkbox"/> Codeine              |
| <input type="checkbox"/> Ibuprofen (Motrin or Advil) | <input type="checkbox"/> Xylocaine      | <input type="checkbox"/> Darvon               |
| <input type="checkbox"/> Tylenol                     | <input type="checkbox"/> Benzocaine     | <input type="checkbox"/> Demerol              |
| <input type="checkbox"/> Penicillin                  | <input type="checkbox"/> Nitrous Oxide  | <input type="checkbox"/> Vicodin              |
| <input type="checkbox"/> Tetracycline                | <input type="checkbox"/> Valium         | <input type="checkbox"/> Others (list below): |
| <input type="checkbox"/> Erythromycin                | <input type="checkbox"/> Sleeping Pills | _____                                         |
| <input type="checkbox"/> Other Antibiotics           | <input type="checkbox"/> Percodan       | _____                                         |
| <input type="checkbox"/> General Anesthesia          | <input type="checkbox"/> Iodine         | _____                                         |

## Medication History

List all pills or medication you are now taking or have taken recently.

Medication	Times or mg/day	For What Condition

## General History

### General

- |                                                                                  |          |                                                        |          |
|----------------------------------------------------------------------------------|----------|--------------------------------------------------------|----------|
| Do you have chest pain upon exertion?                                            | Yes   No | Have you used the drugs Fen-Phen or Redux in the past? | Yes   No |
| Are you short of breath after mild exercise?                                     | Yes   No | Do you have a latex allergy?                           | Yes   No |
| Do your ankles swell?                                                            | Yes   No |                                                        |          |
| Do you get short of breath when you lie down, or require extra pillows to sleep? | Yes   No | <b>Female</b>                                          |          |
| Do you have to urinate more than six times per day?                              | Yes   No | Are you pregnant or nursing?                           | Yes   No |
| Are you thirsty much of the time?                                                | Yes   No | Are you planning a pregnancy in the near future?       | Yes   No |
| Is your mouth frequently dry?                                                    | Yes   No | Are you taking birth control pills?                    | Yes   No |
| Have you recently experienced weight loss, fever, chills or fungal infection?    | Yes   No |                                                        |          |

Do you have any disease, condition, or problem not listed above? Yes | No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

## Alcohol and Smoking History

**Alcohol Consumption:** Drinks or Beers per day (check below)

- |                                                |                                              |                                           |
|------------------------------------------------|----------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> History of alcoholism | <input type="checkbox"/> 2 or 3 drinks daily | <input type="checkbox"/> Occasional drink |
| <input type="checkbox"/> Several drinks daily  | <input type="checkbox"/> One drink daily     | <input type="checkbox"/> None             |

**Do you or have you used tobacco products?****Yes | No****Present Use?****Yes | No**

Type: \_\_\_\_\_

Amount: pack/day \_\_\_\_\_ for \_\_\_\_\_ Years

**Have your previous doctors advised you that tobacco use is associated with gum infection (Periodontitis) as well as Oral Cancer, Lung****Cancer and Heart Attack? Yes | No**

## Dental History

**Are you in pain at the present time?**

Yes | No

Are you very concerned or apprehensive about dental treatment?

Yes | No

Are you having any dental problems now?

Yes | No

Have you had any serious trouble associated with any previous dental treatment?

Yes | No

If yes, please list: \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Have you ever received periodontal (gum) treatment before?

Yes | No

Have you ever had abnormal bleeding associated with previous extractions, surgery, trauma or cuts?

Yes | No

If yes, when: \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Has your dentist discussed the cause and treatment of your periodontal problems?

Yes | No

Are you under significant stress at the present time?

Yes | No

Has your dentist discussed restorative treatment with you?

Yes | No

Have you ever had a medical condition requiring an antibiotic prior to dental care?

Yes | No

If yes, please check the suggested treatment:

If yes, please explain: \_\_\_\_\_

 Crowns    Bridges    Partial Dentures Full Dentures    Implants

I certify I have read and understand the above. I acknowledge that my questions about the above history have been answered to my satisfaction. If ever I have any change in my health or in the medication I take, I will inform the Doctor and his staff at the next appointment without fail. I will not hold the Doctor or any member of his staff responsible for any errors or omissions that may have been made in the completion of this form.

**Consent:** I authorize Dr. Fleming, Dr. Millard or their assistants to take radiographs, study models, photographs and/or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs. I also authorize release of any information relating to this claim. I also understand that responsibility for payment for Dental Services provided by this office for me and/or my dependents is solely mine, due and payable at the time services are rendered, unless financial arrangements have been made in advance. I hereby authorize payment directly to the below-named dentist of insurance benefits otherwise payable to me. I understand that where appropriate, credit bureau reports may be obtained.

\_\_\_\_\_  
Signature of Patient, Parent or Guardian\*\_\_\_\_\_  
Signature of Insured, if different from Patient\*\_\_\_\_\_  
Jeff S. Fleming, DDS, MS\_\_\_\_\_  
Gary D. Millard, DDS\_\_\_\_\_  
Dental Assistant\_\_\_\_\_  
Date

\*You may wait to sign the consent for treatment until after you review this form with Dr. Fleming or Dr. Millard