VAN DENTISTRY
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WELCOME

Please complete this form in ink. Please advise if you have any questions or need assistance.

Patient Information (Confidential) Today's date: _____

Name: _____ **Preferred:** _____

SS#: _____ **Date of Birth:** _____

Address/City/State/Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Do you prefer to receive calls at your: □ Home □ Work □ Cell Phone

Patient or Parent/Guardian's Employer: _____ Work #: _____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____ Phone #: _____

Responsible Party

Name of person responsible for this account: _____ Relationship to patient: _____

Address: _____ Phone #: _____

Driver's license #: _____ Date of Birth: _____ SS#: _____

Employer: _____ Work #: _____

Is this person currently a patient in our office? □ Yes □ No

Insurance Information

Name of insured: _____ Relationship to patient: _____

SS#: _____ Date of Birth: _____

Employer: _____ Work #: _____

Insurance company: _____ Member's ID #: _____

Insurance Phone #: _____

Do You Have Any Additional Insurance? □ Yes □ No If Yes, complete the following:

Name of insured: _____ Relationship to patient: _____

SS#: _____ Date of Birth: _____

Employer: _____ Work #: _____

Insurance company: _____ Member's ID #: _____

Insurance Phone #: _____

Office Note: _____

-OVER PLEASE-

Patient Medical History

Physician: _____ Office #: _____ Date of last exam: _____

	Yes	No
-Are you under medical treatment now?	□	□
-Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years	□	□
*If yes, please explain _____		
-Are you taking any medication(s) including non-prescription drugs?	□	□
*If yes, please state _____		
-Have you taken Fen-Phen/Redux?	□	□
-Do you use tobacco?	□	□
-Do you use controlled substances?	□	□
-Are you wearing contact lenses?	□	□

-Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anesthetics (e.g. Novocain)	□	□
Penicillin or any other antibiotics	□	□
Sulfa drugs	□	□
Barbiturates	□	□
Sedatives	□	□
Iodine	□	□
Aspirin	□	□
Any metals (e.g. nickel, mercury, etc…)	□	□
Latex Rubber	□	□
Other (please list)_____	□	□

-Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)

-Women Only:

●Are you pregnant or think you may be pregnant?	□	□
●Are you nursing?	□	□
●Are you taking oral contraceptives?	□	□

Do you have any medical conditions that require antibiotics before dental treatment? _____

Please check all that apply:

□ Asthma	□ AIDS / HIV infection	□ Angina	□ Anemia
□ Arthritis	□ Allergies/Hay fever	□ Cardiac Pacemaker	□ Cancer
□ Chest Pains	□ Diabetes	□ Epilepsy/Convulsions	□ Emphysema
□ Easily Winded	□ Fainting/Seizures	□ Frequently Tired	□ Glaucoma
□ High / Low Blood Pressure	□ Heart Attack	□ Heart Disease / Trouble	□ Heart Murmur
□ Hepatitis / Jaundice	□ Joint Replacement/Implant	□ Kidney Diseases	□ Leukemia
□ Liver Disease/Jaundice	□ Mitral Valve Prolapse	□ Radiation/Chemo Therapy	□ Recent Weight Loss
□ Respiratory Problems	□ Rheumatic/Scarlet Fever	□ Sexually Transmitted Disease	□ Sickle Cell
□ Stomach Troubles/Ulcers	□ Stroke	□ Swollen Ankles	□ Thyroid Problem
□ Tuberculosis			

Any other illnesses/conditions/surgeries/medical treatments not mentioned above? _____

Patient Dental History - Name of previous dentist/location _____ Date of last exam _____

Reason for seeking care today: □ Routine exam/cleaning □ Specific problem _____

	Yes	No
Do your gums bleed while brushing or flossing	□	□
Are your teeth sensitive to hot or cold liquids/foods	□	□
Are your teeth sensitive to sweet or sour liquids/foods	□	□
Do you feel pain to any of your teeth?	□	□
Do you have any sores/lumps in or near your mouth?	□	□
Have you any head, neck or jaw injuries?	□	□
Have you any of the following problems in your jaw?	□	□
Clicking / Pain (joint, ear, side of face) / Difficulty with open/close/chew		

	Yes	No
Do have frequent headaches?	□	□
Do you clench or grind your teeth	□	□
Do you bite your lips or cheeks frequently?	□	□
Have you ever had any difficult extractions?	□	□
Have you prolonged bleeding after extractions?	□	□
Have you had any orthodontic treatment?	□	□
Do you wear dentures or partials?	□	□
If yes, date of placement _____		

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____

Signature of patient Date