

Specs Family Dentistry, PC

Patient Information

Name _____ Birth Date _____ Social Security # _____

Address _____ How long _____

City _____ State _____ Zip _____

Previous Address _____

Telephone numbers; Home _____ Work _____

Pager _____ Mobile _____

(Please check best number to reach you.)

Employer _____ How long _____ Position _____

Address _____ Telephone # _____

City _____ State _____ Zip _____

May we contact you at work? Yes No

Spouse _____ Birth Date _____ Social Security # _____

Employer _____ How long _____ Position _____

Address _____ Telephone # _____

City _____ State _____ Zip _____

Dental Insurance _____ Account # _____ Payer ID# _____

Address _____ Telephone # _____

City _____ State _____ Zip _____

Dependents \ Children (names) _____

Nearest relative not to living with you _____

Relationship _____ Telephone # _____

Patient Signature _____ Date _____

Please continue on reverse side.

PLEASE ANSWER EACH QUESTION

Are you allergic to any medications or latex? Yes No If so, what? _____

Have you had any excessive bleeding requiring special treatment? Yes No If so, what? _____

Has anyone in your family been advised of difficulty during anesthesia? Yes No

Women: Is there any chance that you are pregnant now? Yes No Nursing? Yes No

Have you been under the care of a physician during the past two years? Yes No

Reason: _____

Have you taken any kind of medication during the past two years? Yes No

Reason & Name _____

Are you taking any medication now? Yes No If so what & why? _____

Have you been a patient in the hospital? Yes No In patient/Out patient? _____

Date/Reason: _____

Check any of the following that you have had:

- | | | |
|---|---|--|
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart lesion | <input type="checkbox"/> AIDS | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> ARC | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Psychiatric treatment |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Other | |

Do you grind your teeth? _____ Day Night

Have you ever had canker sores or cold sores? Yes No

Have you ever had trouble with previous dental treatment such as, dizziness, fainting, or reaction to anesthetic? Yes No

Do your teeth feel sore when you bite on them? Yes No

Do hot, cold, or sweet beverages cause pain or discomfort? Yes No

Do you have any lumps or sores in your mouth now? Yes No

Do you feel you are in good health today? Yes No

Why are you here today? _____

Approximate date of your last dental visit: _____

If you are a new patient, how did you hear about our office? _____