PATIENT INFORMATION

DATE _____

NAME _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

ADDRESS _____
STREET APT.# CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME# WORK# FAX# E-MAIL

PLACE OF EMPLOYMENT _____ SS# _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐PATIENT ☐SPOUSE ☐FATHER ☐MOTHER ☐GUARDIAN

INSURANCE INFORMATION

ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY			
LAST		FIRST	M
STREET	CITY	STATE	ZIP
HOME#	WORK#	FAX#	E-MAIL
BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT	
EMPLOYER		DENTAL INS. CO.	
SS#	SUBSCRIBER#		GROUP#

SECONDARY INSURED			
LAST		FIRST	M
STREET	CITY	STATE	ZIP
HOME#	WORK#	FAX#	E-MAIL
BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT	
EMPLOYER		DENTAL INS. CO.	
SS#	SUBSCRIBER#		GROUP#

OTHER THAN THE NAMES ABOVE, WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY?

NAME RELATIONSHIP PHONE#

WHOM DO WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

SMILE EVALUATION

	YES	NO
1. Are you pleased and confident with the way your teeth look when you smile?	☐	☐
2. Do you have some unwanted spaces or gaps between your teeth?	☐	☐
3. Is there a chip or crack that you would like to have repaired?	☐	☐
4. Are you concerned about one or perhaps more than one tooth that is discolored?	☐	☐
5. Would you be interested in whitening your teeth?	☐	☐
6. Do you have some unattractive discolored metal fillings you would like replaced?	☐	☐
7. Do you have teeth that are slightly out of line, overlapping or protruding?	☐	☐
8. Do you have some missing teeth that should be replaced?	☐	☐

MEDICAL HISTORY

HEALTH QUESIONNAIRE IDENTIFIERS

Possible Risk from Oral Bacteremia:

YES NO Artificial heart valve replacement
YES NO History of bacterial endocarditis
YES NO Congenital heart disease (type _____)
YES NO Acquired valvular heart disease or heart murmur
YES NO Organ transplantation
YES NO Artificial implant or graft of any kind other than above (list _____)
YES NO Systemic lupus erythematosus (SLE)
YES NO Immunosuppression?
YES NO Have you had your spleen removed?
YES NO Physician requests antibiotic coverage for dental treatment for reasons other than above (reason _____)
YES NO **DO YOU HAVE ANY ARTIFICIAL JOINTS?** (If yes, answer questions below)

1. How long have you had the prosthetic joint? (Date of surgery_____)
2. Have you had any problems with the joint since it was replaced? **YES NO**
3. Is your immune system suppressed by disease, medications, or treatments? **YES NO**

Do you now have or have you ever had any of the following:

YES	**NO**	Stroke	**YES**	**NO**	Cancer
YES	**NO**	Epilepsy or Seizures	**YES**	**NO**	Chemotherapy
YES	**NO**	Excessive Bleeding or Bruising	**YES**	**NO**	Stomach/Intestinal Disease
YES	**NO**	Breathing Problem	**YES**	**NO**	Kidney Problems
YES	**NO**	Tumors or Growths	**YES**	**NO**	Hepatitis A, B, or C (Infectious)
YES	**NO**	Asthma	**YES**	**NO**	Arthritis/Gout
YES	**NO**	Emphysema	**YES**	**NO**	AIDS
YES	**NO**	Tuberculosis	**YES**	**NO**	HIV Positive
YES	**NO**	Diabetes	**YES**	**NO**	High Blood Pressure
YES	**NO**	Heart Attack/ Cardiovascular Disease			

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? **YES NO**

Have you been treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? **YES NO**
Date Treatment Began _____

Have you ever had any serious illness not marked above? Describe_____

YES NO Are you under medical care now? If so, for what? _____

YES NO Are you taking any medications/supplements now? Please list: _____

YES NO Are you **ALLERGIC** to any medications or substances?
Please circle: Local Anesthetics Penicillin Codeine Acrylic Metal Latex Rubber
Other: _____

FEMALES: Are you pregnant? ☐**YES** ☐**NO** Are you nursing? ☐**YES** ☐**NO** Using birth control pills/implants? ☐**YES** ☐**NO**

I, the undersigned, affirm the information given on this form to be accurate. This information will be utilized for evaluation and treatment by the staff at Lindale Dental Care.
DATE_____ SIGNATURE_____ DR. INITIAL _____

REVIEW OF HEALTH HISTORY FORM BY PATIENT
Please sign below to indicate you have reviewed and updated your health history.

DATE	SIGNATURE	DATE	SIGNATURE