



Welcome to our office. So that we may become better acquainted, please complete the following confidential information.

PATIENT INFORMATION

Date _____

Name _____
Last First Nickname

Address _____
Street Apt.# City State Zip

Home Phone _____ Birthday _____ School _____ E-mail _____

Whom may we thank for referring you to our office? _____

Are other family members under treatment at this office? _____

Who is responsible for the account? _____

Custodial Parent (When applicable) _____

FAMILY INFORMATION Parents Marital Status: Married Divorced Separated Single Widowed

FATHER

MOTHER

LAST	FIRST	MIDDLE			
RESIDENCE - STREET	APT.#	CITY	STATE	ZIP	
MAILING - STREET		CITY	STATE	ZIP	
(Previous Address - if less than 3 years)	STREET	CITY	STATE	ZIP	
OCCUPATION					
EMPLOYER	YEARS EMPLOYED				
DATE OF BIRTH	SOC.SEC.#				
HOME PHONE #	WORK PHONE #				
E-MAIL					

LAST	FIRST	MIDDLE			
RESIDENCE - STREET	APT.#	CITY	STATE	ZIP	
MAILING - STREET		CITY	STATE	ZIP	
(Previous Address - if less than 3 years)	STREET	CITY	STATE	ZIP	
OCCUPATION					
EMPLOYER	YEARS EMPLOYED				
DATE OF BIRTH	SOC.SEC.#				
HOME PHONE #	WORK PHONE#				
E-MAIL					

INSURANCE INFORMATION

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Telephone # _____

Do you have dual coverage? Yes No

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Telephone# _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____ Telephone _____

CONTINUED ON REVERSE

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____

Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes No Is your general health good?
If NO, explain _____
2. Yes No Has there been a change in your health within the last year?
If YES, explain _____
3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
If YES, explain _____
4. Yes No Are you being treated by a physician now? If YES, explain _____
Date of last medical exam? _____ Reason for exam _____
5. Yes No Have you had problems with prior dental treatment?
If YES, explain _____
Date of last dental exam _____ Name of last treating dentist _____
6. Yes No Are you in pain now?
If YES, explain _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please Circle)

Chest pain (angina)	Blood in stools	Frequent vomiting
Fainting spells	Diarrhea or constipation	Jaundice
Recent significant weight loss	Frequent urination	Dry mouth
Fever	Difficulty urinating	Excessive thirst
Night sweats	Ringing in ears	Difficulty swallowing
Persistent cough	Headaches	Swollen ankles
Coughing up blood	Dizziness	Joint pain or stiffness
Bleeding problems	Blurred vision	Shortness of breath
Blood in urine	Bruise easily	Sinus problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)

Heart disease	AIDS/HIV	Psychiatric care
Family history of heart disease	Surgeries	Osteoporosis
Heart attack	Hospitalization	Thyroid disease
Artificial joint	Diabetes	Asthma
Stomach problems or ulcers	Family history of diabetes	Hepatitis
Heart defects	Tumors or cancer	Sexual transmitted disease
Heart murmurs	Chemotherapy	Herpes
Rheumatic fever	Radiation	Canker or cold sores
Skin disease	Arthritis, rheumatism	Anemia
Hardening of arteries	Emphysema or other lung disease	Liver disease
High blood pressure	Kidney or bladder disease	Eye disease
Seizures	Stroke	Transplants
Cosmetic surgery	Eating disorders	Tuberculosis

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please Circle)

Aspirin	Valium	Tetracycline
Darvon	Demerol	Vicodin
Codeine	Penicillin	Percodan
Local anesthetic (Novacaine or Xylocaine)	Latex	Food
Nitrous oxide	Erythromycin	Metal
Others: _____		

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please Circle)

Recreational drugs	Tobacco in any form	Antibiotics
Over-the-counter medicines	Alcohol	Supplements
Weight loss medications	Bisphosphonate (Fosamax)	Aspirin
Please list: _____		

DENTAL HISTORY

Patient's Dentist _____ Date of last visit _____

VI. WOMEN ONLY

Yes No Are you or could you be pregnant?
If YES, what month?
Yes No Are you nursing?
Yes No Are you taking birth control pills?

VII. ALL PATIENTS

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain:
Yes No Have you ever been pre-medicated for dental treatment? If YES, why
Yes No Have you ever taken Fen-phen? If YES, when

Yes No Is there any issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

ORTHODONTIC INFORMATION

Reason for consultation?
Who noticed orthodontic problem?
Other orthodontic examinations?
Other orthodontic treatment?
Is patient self-conscious about his/her teeth?
Has anyone in your family had orthodontic treatment?
Name and ages of other children in your family

PHOTOGRAPHIC SUBJECT MODEL RELEASE:

I authorize Dr. Craig Davis to publish photographs in which I am a recognizable subject. I understand there will be no remuneration to me or anyone representing me as a result of appearing in the aforementioned photographs.

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's if minor)

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature (Parent's if minor) Date

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Table with 4 columns: DATE, PATIENT SIGNATURE, CHANGES TO HEALTH HISTORY, DENTIST INITIALS