PATIENT INFORMATION (Please Print)

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name:_____ Date of birth:_____ Sex:_____

Home address:_____ City:_____ State:_____ Zip:_____

Billing address (if different):_____ City:_____ State:_____ Zip:_____

Home phone:_____ Cell:_____ SS #:_____

Driver's license #:_____ State:_____ E-mail:_____

Employer/Occupation:_____ Referred to us by:_____

Emergency Contact : Name_____ phone #_____

Relationship_____

Dental Insurance Info: Primary dental insurance:_____ Phone#_____

Group #:_____ ID #: _____

Subscriber's name:_____ Date of birth: _____ SS #:_____

Secondary dental insurance:_____ Phone#_____

Group #:_____ ID #: _____

Subscriber's name:_____ Date of birth: _____ SS #:_____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ (name of insurance co.) and assign directly to Connect Family Dental all insurance benefits. If any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dental facility may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will stay in effect as long as payments for rendered dental services have been payed off and I am a petient with Connect Family Dental.

_____ _____

Signature of Patient, Parent or Guardian | Print Name of Signing Patient, Parent or Guardian

_____ _____

Date | Relationship to Patient

DENTAL HEALTH HISTORY

Reason for today's visit_____ Former Dentist_____ Date of last visit_____

Date of last X-rays_____ How often do you brush?_____ floss? _____

Do you	Yes	No	Do you have	Yes	No	Do you have	Yes	No	Do you have	Yes	No
Gag easily?	☐	☐	Dry mouth?	☐	☐	Clicking or popping of Jaw?	☐	☐	Blisters on lip/mouth?	☐	☐
Wear dentures?	☐	☐	Bleeding gums?	☐	☐	Loose teeth or filling?	☐	☐	Burning on tongue?	☐	☐
Catch food between teeth?	☐	☐	Broken filling/ tooth?	☐	☐	Swelling or other pain?	☐	☐	Foreign objects?	☐	☐
Chew one side of mouth?	☐	☐	Bad breath?	☐	☐	Difficulty in chewing food?	☐	☐	Mouth Breathing?	☐	☐
Take fluoride supplements?	☐	☐	TMJ disorder?	☐	☐	pain in/ front of ear?	☐	☐	Sensitive teeth?	☐	☐
Bite Nail, Lip or cheek?	☐	☐	Jaw pain?	☐	☐	Periodontal treatment?	☐	☐	Growth in mouth?	☐	☐
Grind/Clench teeth	☐	☐	Tooth/ Gum Pain?	☐	☐	Ortho treament or braces?	☐	☐	Blow to jaw(trauma)?	☐	☐

MEDICAL HEALTH HISTORY:

Patient (Printed) name:_____

Do you have, or have you had, any of the following? Please check yes or no.

	Yes	No
Heart Problems	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nose bleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Required blood transfusion?	☐	☐
Allergy Problems	☐	☐
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐

	Yes	No
Rheumatic Fever	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Kidney or bladder problems	☐	☐
Swollen Neck/Glands	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back/Neck Pain/Problems	☐	☐
Joint replacement (e.g., total hip, pins, implants)	☐	☐
Glaucoma	☐	☐
Stroke(s)	☐	☐
HIV-positive/AIDS	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Chemical Dependency	☐	☐
Chemotherapy	☐	☐
Cancer/Tumor	☐	☐
Radiation treatment	☐	☐

	Yes	No
Diabetes	☐	☐
Fainting Spells or Seizures	☐	☐
Epilepsy or other neurological disease	☐	☐
Tuberculosis/Other respiratory disease	☐	☐
Do you drink alcohol?	☐	☐
If so, how much?		
Do you smoke?	☐	☐
If so, how much?		
Hepatitis, jaundice, or liver trouble	☐	☐
Liver Disease	☐	☐
Herpes or other STD	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Psychiatric Care	☐	☐
Nervous Problem	☐	☐
Premedications required by physician	☐	☐
History of alcohol or drug abuse	☐	☐

Any disease, condition, or problem not listed_____

- Have you ever taken any of group of drugs collectively referred to as 'fen-phen'? These include combinations of Ionomin, Adipex, Fastin (brand names of phenteramine), Pondimin (fenfluramine) and Redux (dexfenfluramine) **Yes** **No**

Are you allergic, or have you reacted adversely, to any of the following? Please circle or mark them.

Local anesthetics ("Novocaine")	**Latex**
Penicillin or other antibiotics	**Codeine**
Sulfa drugs	**Ibuprofen**
Acetaminophen	**Aspirin**
Other_____	**None**

For Women

	Yes	No
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date:		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐

During the past 12 months, have you taken any of the following?

	Yes	No
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐

Other_____

Notes:_____

Medical Doctor's Name_____Phone:_____

Patient / Parent / Guardian Signature _____ Date: _____

Doctor's Signature: _____