Patient Information Form

For the offices of

Hyacinth Brown, DDS

In order to provide you with thorough and comprehensive dental care the following information is requested. All disclosed information will be kept confidential according to the rules and guidelines of H.I.P.A.A.

PLEASE PRINT

Patient Information

Patient Name_____
Last **First** **Title** **MI** **(Preferred Name)**

Social Security #_____ Birth Date_____ Gender (M/F)_____ Marital Status_____

Home Address_____
Street Address **City** **State** **Zip code**

Phone numbers_____ _____ _____ _____
Home **Work (+ ext.)** **Cellular** **E-Mail Address**

Employer _____
Company Name **City/State** **Position**

Emergency Contact _____
Name **Relation** **Phone Number**

Who will be responsible for payment for this account? _____

Spouse Information

Spouse's Name _____
Last **First** **Title** **MI** **(Preferred Name)**

Employer _____
Company Name **City/State** **Position**

Referral Information

Whom may we thank for referring you to our dental practice?

❑ Another patient _____ ❑ Yellow Pages
Name

❑ Dentist/specialist/physician _____ ❑ Other _____
Name Name

Insurance Information

Primary Insurance

Insurance Company_____
Company Name **Company Phone number**

Name of Insured _____
Last First MI Social Security #

Insured's Birth Date_____ID# _____Group# _____

Insured's Address (if different than patient) _____

Patient's relationship to insured: ❑Self ❑Spouse ❑Child ❑Other _____
Explain

Secondary Insurance

Insurance Company_____
Company Name **Company Pone number**

Name of Insured_____
Last **First** **MI** **Social Security #**

Insured's Birth Date_____ID#_____Group#_____

Insured's Address (if different than patient) _____

Patient's relationship to insured: ❑Self ❑Spouse ❑Child ❑Other_____
Explain

Dental Information

Pt. Name_____

Please answer the following questions to help us familiarize ourselves with your dental history, current dental situation and future dental goals.

Purpose for today's appointment _____

Previous dentist_____
Name Address Phone Number

Date of last dental visit_____ What for?_____
(month/year)

Date of last dental x-rays_____ Why did you change dentists? _____
(month/year)

Please check the answer the following questions.

Yes	No	
❑	❑	Have you ever had an allergic reaction to latex? Describe _____
❑	❑	Have you ever had an adverse reaction to local anesthetic? (i.e. Novocaine) Describe_____
❑	❑	Do you request Nitrous Oxide during dental procedures? ❑ cleanings ❑ restorative treatment
❑	❑	Have you had any serious trouble associated with previous dental treatment?_____
❑	❑	Do you have a fear of going to the dentist? Comments _____
❑	❑	Do you have trouble eating and chewing foods satisfactorily? _____
❑	❑	Have you ever had braces or orthodontic treatment?_____
❑	❑	Have you ever had periodontal (gum) treatment? When? _____
❑	❑	Do you floss? How often? _____
❑	❑	Do you play any sports? List _____
❑	❑	Do you wear any of the following? ❑ night guard ❑ snoring device ❑ orthodontic appliance ❑ sports guard
❑	❑	Do you snore, have trouble sleeping or breathing while you sleep?
❑	❑	Have you ever whitened your teeth?
❑	❑	Are you happy with the appearance of your teeth?
❑	❑	Are you interested in information about cosmetic dental procedures?
❑	❑	Are there any specific questions you would like answered by the dentist? _____
❑	❑	Is there any dentistry that was recommended to you that has not yet been completed

_____

For the following questions check all that apply.

I am currently experiencing sensitivity or pain in my head, neck, or mouth from the following: (None ❑)

❑ hot ❑ sour ❑ chewing ❑ touch
❑ cold ❑ sweet ❑ other _____
(explain)

The pain or sensitivity is: (None ❑)

❑ sharp pain ❑ constant ❑ goes away immediately ❑ wakes you from sleep ❑ started when?_____
❑ dull ache ❑ intermittent ❑ lasts hours ❑ lasts days ❑ other _____
(explain)

)

Do you ever experience any of the following symptoms in or around your head, neck, or mouth?

❑ swelling ❑ bleeding gums ❑ gumboils ❑ jaw clicking ❑ jaw popping ❑ food catching ❑ red patches ❑ white patches
❑ blisters ❑ ulcers ❑ headaches ❑ ear aches ❑ lumps ❑ cold sores ❑other _____
(explain)

I presently have in my mouth: (None ❑)

❑ silver fillings ❑ crowns ❑ removable partials or dentures ❑ cosmetic bonding ❑ unfilled cavities
❑ tooth colored fillings ❑ fixed bridges ❑ dental implants ❑ porcelain veneers ❑ inlays/onlays

I am interested in the following dental care:

❑ Complete dental care that emphasizes treating dental concerns early to prevent future problems including replacement of missing teeth, periodontal (gum) treatment and crowns where necessary.
❑ Maintenance dental care that will maintain my current dental status with tooth colored fillings and preventive maintenance.
❑ Emergency dental care to treat my present problem only.

I would prefer:

❑ **fewer** appointments for a longer length of time ❑ local anesthetic for treatment
❑ multiple appointments for **shorter** length of time ❑ medication i.e. Valium for treatment

I have or would postpone dental treatment because of the following:

❑ fear ❑ cost ❑ time ❑ lack of concern ❑ other

Medical History

Pt. Name_____

Name of current physician_____ Date of last appointment_____
Month/year

Physician's address_____ Phone number _____

Please list all vitamins, prescription, over the counter, and homeopathic medication(s) you are currently taking and why:

_____

Please check the answer the following questions.

Yes	No	
❑	❑	Are you in good health?
❑	❑	Are you presently being treated for any condition(s) by a physician? Explain_____
❑	❑	Have you had any serious illness, operation, or been hospitalized in the past 5 years? Explain_____
❑	❑	Has anyone in your family been diagnosed with oral cancer?
❑	❑	Do you drink alcohol? _____ How often ?
❑	❑	Do you routinely use mouth rinses? _____ What type? How often?
❑	❑	Do you use tobacco products? _____ What type? How often?
❑	❑	If you use tobacco products would you like help to stop?

Women only

❑	❑	Are you taking birth control pills?
❑	❑	Are you or do you suspect that you may be pregnant? Due date_____
❑	❑	Are you nursing?
❑	❑	Are you on hormone replacement therapy?

Please check all that apply

Have you ever had any of the following? ❑ To my knowledge I do not have any of the following conditions.

- ❑ AIDS
- ❑ Allergy-Aspirin
- ❑ Allergy-Codeine
- ❑ Allergy-Sulfa
- ❑ Allergy- Penicillin
- ❑ Allergy-Other Antibiotics
- ❑ Allergy Other_____
- ❑ Anemia
- ❑ Artificial joint_____
- ❑ Asthma
- ❑ Blood Disease_____
- ❑ Cancer_____
- ❑ Chemical dependency
- ❑ Chest pain
- ❑ Chronic diarrhea
- ❑ Circulatory problems
- ❑ Contact lenses
- ❑ Diabetes
- ❑ Difficulty breathing
- ❑ Dizziness
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Excessive bleeding
- ❑ Fainting
- ❑ Glaucoma
- ❑ Hay fever
- ❑ Head injuries
- ❑ Headaches _____
- ❑ Heart disease
- ❑ Heart murmur (MVP)
- ❑ Hemophilia
- ❑ Hepatitis_____ type
- ❑ Hip replacement
- ❑ HIV infection
- ❑ High blood pressure
- ❑ Jaundice
- ❑ Kidney disease
- ❑ Knee replacement
- ❑ Liver disease
- ❑ Low blood pressure
- ❑ Nervous disorder
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Problems w/immune system
- ❑ Psychiatric care
- ❑ Radiation treatment
- ❑ Respiratory problems
- ❑ Rheumatic fever
- ❑ Rheumatism
- ❑ Seizures
- ❑ Sickle cell disease
- ❑ Sinus problems
- ❑ Special diet_____
- ❑ Stomach problems
- ❑ Stroke
- ❑ Swollen neck glands
- ❑ Thyroid problems
- ❑ Tuberculosis
- ❑ Transfusion
- ❑ Transplant_____
- ❑ Tumors
- ❑ Ulcers
- ❑ Venereal disease
- ❑ Other_____

Have you ever been told by a physician you must take pre-medication (antibiotics) before dental treatment?
Explain_____

Do you have any disease, condition, or problem not listed above that you think the doctor should know about?
Explain_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in completion of this form.

_____ Date _____

Signature of patient, parent or guardian