PATIENT INFORMATION HERALD SQUARE DENTAL & THE DENTURE CENTER

❑ Mr. ❑ Ms.
❑ Miss ❑ Mrs. _____ _____
PATIENT LAST NAME FIRST MI DATE OF BIRTH

ADDRESS APT # CITY STATE ZIP

EMPLOYER NAME & ADDRESS CITY STATE ZIP

HOME PHONE ( ) SOC. SEC. NUMBER

BUSINESS PHONE ( ) E-MAIL ADDRESS

CELL PHONE ( ) NAME & PHONE OF NEAREST RELATIVE NOT LIVING WITH YOU

DENTAL INSURANCE-NAME-GROUP NUMBER

HOW DID YOU HEAR ABOUT US/REFERRED BY?

DENTAL HISTORY

Please check any of the following that apply to you:

❑ Sensitivity (hot, cold, sweet) Where? UR LR UL LL
❑ Headaches, ear aches, neck or jaw joint pain
❑ Mouth ulcers or cold sores
❑ Teeth or fillings breaking
❑ Grinding or clenching teeth
❑ Bleeding, swollen or irritated gums
❑ Loose, tipped or shifting teeth
❑ Bad breath

Do you have or have you had any of the following?

❑ Dentures ❑ Partial dentures
❑ Braces ❑ Gum treatments

Please share the following dates:

Your last cleaning _____
Your last oral cancer screening _____
Your last complete x-rays _____
You last physical exam _____

Name of Previous Dentist _____
City _____
State _____ Phone _____

Name of Family Physician _____
Phone _____

What is the most important thing to you about your future smile and dental health?

_____
_____

Why did you leave your previous dentist?

_____
_____

If you could whiten your teeth for a cost anyone could afford, would you do it? _____

Do you smoke or use chewing tobacco? _____

How much? For how long? _____

If I could change my smile, I would:

❑ Make my teeth whiter
❑ Make my teeth straighter
❑ Close spaces
❑ Replace metal fillings with tooth colored restorations
❑ Repair chipped teeth
❑ Replace missing teeth
❑ Replace old crowns that don't match
❑ Have a smile makeover

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you? _____
Where would you rate your current dental health? _____

Do you have an allergy to any of the following?

❑ Aspirin ❑ Codeine
❑ Erythromycin ❑ Latex
❑ Local Anesthetic ❑ Nitrous Oxide
❑ Penicillin
❑ Other: _____

What medications are you currently taking?

_____
_____

Are you under a physician's care? for what?

_____
_____

What is your primary concern for today's visit?

_____
_____

MEDICAL HISTORY

Please check any of the following that apply to you:

❑ Artificial Heart Valve	❑ Allergies (Seasonal)	❑ Excessive Bleeding	❑ Anemia
❑ Heart Murmur	❑ Asthma	❑ Heart Conditions	❑ Glaucoma
❑ Mitral Valve Prolapse	❑ Hepatitis A, B, C	❑ Blood Disease	❑ Bruise Easily
❑ Artificial Joints	❑ Cancer	❑ Chemotherapy	❑ Diabetes / Sugar
❑ Nervousness/Depression	❑ Liver Disease	❑ Emphysema	❑ Dizziness/Fainting
❑ Respiratory Problems	❑ Pacemaker	❑ Drug Addiction	❑ Radiation (head/neck)
❑ Seizures	❑ Rheumatic Fever	❑ Rheumatism	❑ Scarlet Fever
❑ Tuberculosis	❑ Stomach Problems	❑ Stroke	❑ Thyroid Disease
❑ Kidney Disease	❑ High Blood Pressure	❑ HIV/AIDS	❑ Jaundice
❑ Fatigue	❑ Ulcers	❑ Snoring	❑ Sleep Apnea
❑ Migraines	❑ Chronic Pain	❑ OTHER (please list): _____	

For WOMEN Only

❑ Birth Control Pills ❑ Breast-feeding ❑ Pregnant 1-3 mos ____ 3-6 mos ____ 6-9 mos ____

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. Payment for all treatment and services rendered are my responsibility. All sales final with no returns. I authorize the use of my radiographs and/or photographs for use in seminars or publications of this dental office.

Signature:_____ **Date:**_____

OFFICE USE ONLY

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	NEEDED																
	PRIMARY				A T	B S	C R	D Q	E P	F O	G N	H M	I L	J K			
	NEEDED																

DATE			DESCRIPTION OF TREATMENT	ACCOUNT RECORD					TREATMENT PLAN	FEE
MO	DAY	YEAR		DOCTOR	CHARGE	PAID	BALANCE	INS. BALANCE		