Patient History and Information

How did you hear about Premier Dental Care? : _____

First Name:_____ **Last Name:**_____ **Today's Date:**_____

Preferred Name:_____ **Date Of Birth:**_____ **Age:**_____

○ **Male** **Social Security Number:**_____

○ **Female** ***Email Address:***_____

Mailing Address:_____ **City:**_____ **ST:**____ **Zip:**_____

Home Number:_____ **Cell:**_____ **Alternate:**_____

Employer:_____ **Employer Phone:**_____

Employer Address:_____

Responsible Party:_____ **Relationship:**_____

Address: (If Different)_____ **City:**_____ **ST:**____ **Zip:**_____

Home Number:_____ **Cell:**_____ **Alternate:**_____

Emergency Contact:_____ **Phone :**_____ **Relationship:**_____

Dental Insurance

Primary Insurance Co:_____ **Employer:**_____ **Employee:**_____

ID#:_____ ***Group#:***_____ **Social Security #:**_____ **DOB:**_____

Address:_____ City:_____ ST:____ Zip:_____

Phone:_____ **Payor ID#:**_____

Secondary Insurance Co:_____ **Employer:**_____ **Employee:**_____

ID#:_____ ***Group#:***_____ **Social Security #:**_____ **DOB:**_____

Address:_____ City:_____ ST:____ Zip:_____

Phone:_____ **Payor ID#:**_____

Medical History

Your Physician's Name:_____ **Last Visit Date:**_____

Are you Currently Being Treated For Any Health Condition: **O Yes O No**

*If Yes Explain:*_____ List Any Medications You Are Currently Taking (Include Over The Counter & Prescription):_____

_____

Are You taking Any Bisphosphonates, If So, What? : **O Yes O No**

O Fosamax **O Boniva** **O Actonel** **O Aredia**

Have You Ever Had An Allergic Or Unusual Reaction To Any Medications: **O Yes O No**

O Codeine **O Sulfa** **O Penicillin** **O Anesthetics** **O Latex** **O Other**

*Please Explain Reaction:*_____

Do You Have Any History Of The Following: Please Answer Yes Or No

Hepatitis	**Arthritis**	**Stroke**
O Yes O No	O Yes O No	O Yes O No
AIDS Or HIV	**Epilepsy**	**Liver Disease Or Jaundice**
O Yes O No	O Yes O No	O Yes O No
Rheumatic Fever	**Asthma**	**Lung Disease**
O Yes O No	O Yes O No	O Yes O No
Heart Problems	**Anemia**	**Kidney Disease**
O Yes O No	O Yes O No	O Yes O No
High Blood Pressure	**Diabetes**	**Tuberculosis**
O Yes O No	O Yes O No	O Yes O No
Heart Valve Problems	**Cancer Or Tumor**	**Venereal Disease**
O Yes O No	O Yes O No	O Yes O No
Heart Murmur	**Artificial Joint/Pins**	**Women-Are You Pregnant?**
O Yes O No	O Yes O No	O Yes O No

Do you Have Any Other Health Condition That We Should Be Aware Of? **O Yes O No**
*If Yes, Please Explain:*_____

Dental History

Do You Like The Appearance Of Your Teeth And Smile? **O Yes O No**
*If Not, Please Explain:*_____
Do You Like The Color Of Your Teeth? **O Yes O No**
*If Not, Please Explain:*_____
Do You Frequently Have Headaches or Any Discomfort In Your Jaw Joint? **O Yes O No**
Have You Ever Been Treated for TMJ Dysfunction (Jaw Joint Problems)? **O Yes O No**
*If Yes, Please Explain:*_____
When Was The Last Time Your Teeth Were Cleaned In A Dental Office?_____
When Was The Last Time You Had A Full Mouth X-Rays Taken?_____
Are You Aware That You Have Any Of The Following?
Frequent Bad Breath O Dull Ache In Gums O Bleeding Gums O Loose Or Shifting Teeth O
Have You Ever Been Treated For or Diagnosed With *Periodontal (Gum) Disease*? **O Yes O No**
*If yes, Please Explain:*_____
Would you Like To Keep Your Natural teeth For Your Lifetime? **O Yes O No**
How Would You Rate The Present Condition Of Your Dental Health?
O Excellent O Average O Poor

Do You Have Any Questions For The Doctor Or Hygienist Today?_____

_____

Patient Name:_____ ***Signature*:**_____

Name of Parent/ Guardian:_____ ***Signature*:**_____