onsite health
work. life. balance.

DATE: ___________

# New Patient Information

| First Name | Middle Initial | Last Name | Date of Birth | Home Phone |
|---|---|---|---|---|

| Address | City | St | Zip Code | Drivers License |
|---|---|---|---|---|

| Social Security | Sex | M | F | Marital Status | Spouses Name |
|---|---|---|---|---|---|

**PATIENT INFORMATION**

| Occupation | Employer | Employer Address |
|---|---|---|

| Employer City | Employer St | Employer Zip Code | Email Address |
|---|---|---|---|

| Alt. Email Address | Work Phone | Fax | Alt. Phone |
|---|---|---|---|

**EMPLOYMENT INFORMATION**

**SPOUSE INFORMATION**

| Spouse Occupation | Employer |
|---|---|
| Work Phone | Email Address |

**EMERGENCY INFORMATION**

| Emergency Contact Person | Relationship |
|---|---|

| Phone Number | Are you a Student? | Yes | No | If yes, Name of School |
|---|---|---|---|---|

**HOW DID YOU HEAR ABOUT ON-SITE DENTAL CARE?**
**(Please Check One)**

? Email ? Saw Dental Practice ? Practice Open House ? Referral

If so, whom? ____________________

? Flyer ? Employee/Student ? Cafeteria Information Visit

? Poster ? Postcard ? Other

**PERSON RESPONSIBLE FOR PAYMENT**
**(If other than patient)**

| First Name | Last Name | Social Security | Drivers License |
|---|---|---|---|
| Street Address | City | St | Zip Code |

| Occupation | Employer | Length of Employment |
|---|---|---|

| Employer Address | City | St | Zip Code | Employer Phone |
|---|---|---|---|---|

## DENTAL INSURANCE INFORMATION

| | Primary Carrier | Secondary Carrier |
|---|---|---|
| Name of Employee | | |
| Employee's Birthday | | |
| Employee's Social Security | | |
| Name of Employer | | |
| Insurance Company | | |
| Insurance Co. Address | | |
| Coverage Effective Date | | |
| Group or Policy Number | | |

# Health History

It is important that we know your Medical and Dental History. These facts have a direct bearing on your dental health. We thank you for taking the time to fill this in as completely as possible.

### I. CHECK THE APPROPRIATE ANSWER

| | YES | NO | |
|---|---|---|---|
| 1. | ☐ | ☐ | **Are you in pain now?** If yes, please describe: ______ |
| 2 | ☐ | ☐ | Is your general health good? |
| 3. | ☐ | ☐ | Has there been a change in your health in the last year? |
| 4. | ☐ | ☐ | Have you ever been hospitalized or had a serious illness in the last three years? If yes, indicate why: ______ |
| 5. | ☐ | ☐ | Are you being treated by a physician now? If yes, please explain: ______ |

Physician's name: ______

Address: ______

Phone number: ______ Date of last medical exam ______

| | YES | NO | |
|---|---|---|---|
| 6. | ☐ | ☐ | Have you had any problems with prior dental treatment? If yes, please describe: ______ |

### II. PLEASE LIST ALL SURGERIES AND HOSPITALIZATIONS.

______ Date: ______

______ Date: ______

______ Date: ______

**III. Please list any current medications and/or drugs you are taking** (please include any non-prescription vitamins & health supplements)

______

**IV. Please list any medications and/or drugs you have become sick from or have shown an allergic reaction to:**

______

### V. HAVE YOU EVER EXPERIENCED:

| | YES | NO | | | YES | NO | |
|---|---|---|---|---|---|---|---|
| 1. | ☐ | ☐ | Chest pain? | 2. | ☐ | ☐ | Angina? |
| 3. | ☐ | ☐ | Swollen ankles? | 4. | ☐ | ☐ | Ringing in ears? |
| 5. | ☐ | ☐ | Shortness of breath? | 6. | ☐ | ☐ | Headaches? |

| | YES | NO | | | YES | NO | |
|---|---|---|---|---|---|---|---|
| 7. | ☐ | ☐ | Recent weight loss, fever, night sweats? | 8. | ☐ | ☐ | Fainting spells? |
| 9. | ☐ | ☐ | Persistent cough, coughing up blood? | 10. | ☐ | ☐ | Blurred vision? |
| 11. | ☐ | ☐ | Bleeding problem, bruising easily? | 12. | ☐ | ☐ | Seizures, Epilepsy? |
| 13. | ☐ | ☐ | Sinus problems? | 14. | ☐ | ☐ | Excessive thirst? |
| 15. | ☐ | ☐ | Difficulty Swallowing? | 16. | ☐ | ☐ | Frequent urination? |
| 17. | ☐ | ☐ | Diarrhea, constipation, blood in stools? | 18. | ☐ | ☐ | Difficulty urinating, blood in urine? |
| 19. | ☐ | ☐ | Frequent vomiting, nausea? | 20. | ☐ | ☐ | Jaundice? (turned yellow) |
| 21. | ☐ | ☐ | Dry mouth? | 22. | ☐ | ☐ | Joint pain, stiffness? |
| 23. | ☐ | ☐ | Anxiety, panic attacks? | 24. | ☐ | ☐ | Dizziness? |

**VI. DO YOU HAVE OR HAVE YOU HAD:**

| | YES | NO | | | YES | NO | |
|---|---|---|---|---|---|---|---|
| 1. | ☐ | ☐ | Heart Disease? | 2. | ☐ | ☐ | Heart attack, heart defects? |
| 3. | ☐ | ☐ | Heart murmurs, mitral valve prolapse? | 4. | ☐ | ☐ | Rheumatic fever? |
| 5. | ☐ | ☐ | Stroke, hardening of the arteries? | 6. | ☐ | ☐ | High blood pressure? |
| 7. | ☐ | ☐ | Hepatitis, other liver disease? | 8. | ☐ | ☐ | Stomach problems, ulcers? |
| 9. | ☐ | ☐ | Head injury? | 10. | ☐ | ☐ | Cold sores? |
| 11. | ☐ | ☐ | AIDS / HIV / Immune Disorder? | 12. | ☐ | ☐ | Tumors, cancer? |
| 13. | ☐ | ☐ | Arthritis, rheumatism? | 14. | ☐ | ☐ | Eye diseases? |
| 15. | ☐ | ☐ | Skin diseases? | 16. | ☐ | ☐ | Anemia? |
| 17. | ☐ | ☐ | VD (syphilis or gonorrhea)? | 18. | ☐ | ☐ | Herpes? |
| 19. | ☐ | ☐ | Kidney, bladder disease? | 20. | ☐ | ☐ | Thyroid, adrenal disease? |
| 21. | ☐ | ☐ | Allergies (food/drugs/meds/latex)? | 22. | ☐ | ☐ | Diabetes? |
| 23. | ☐ | ☐ | Family history of diabetes, tumors or heart problems? | 24. | ☐ | ☐ | Asthma, TB, emphysema, or other lung disease? |
| 25. | ☐ | ☐ | Organ Transplant? | | | | |

**VII. HAVE YOU EVER BEEN TREATED WITH:**

| | YES | NO | | | YES | NO | |
|---|---|---|---|---|---|---|---|
| 1. | ☐ | ☐ | Psychiatric care? | 2. | ☐ | ☐ | Blood transfusions? |
| 3. | ☐ | ☐ | Radiation treatments? | 4. | ☐ | ☐ | Chemotherapy? |
| 5. | ☐ | ☐ | Prosthetic heart valve? | 6. | ☐ | ☐ | Pacemaker? |
| 7. | ☐ | ☐ | Artificial joints? | 8. | ☐ | ☐ | Artificial prosthesis (implant)? |

**VIII. ARE YOU TAKING OR HAVE YOU EVER TAKEN:**

| | YES | NO | | | YES | NO | |
|---|---|---|---|---|---|---|---|
| 1. | ☐ | ☐ | Recreational drugs? | 2. | ☐ | ☐ | Alcohol? |
| 3. | ☐ | ☐ | Fen-Phen, Redux, Steroids, Cortizone | 4. | ☐ | ☐ | Tobacco? |

5 If you have quit any of the above, please indicate when? ______________________________

**IX. ALL PATIENTS:**

| | YES | NO | | | YES | NO | |
|---|---|---|---|---|---|---|---|
| 1. | ☐ | ☐ | Do you wear corrective lenses? | 2. | ☐ | ☐ | Do you wear contact lenses? |

3. ☐ ☐ Do you have or have you had any other diseases or medical problems NOT listed on this form? If yes, please explain: ______________________________

## X. WOMEN ONLY:

| | YES | NO | | | YES | NO | |
|---|---|---|---|---|---|---|---|
| 1. | ☐ | ☐ | Are you or could you be pregnant? | 2. | ☐ | ☐ | Are you anticipating becoming pregnant? |
| 3. | ☐ | ☐ | Are you nursing? | 4. | ☐ | ☐ | Are you taking birth control pills? |

**XI. DENTAL HISTORY:**

1. What is the purpose of your visit today? ______________________________
2. How long has it been since your last dental visit? ______________ Full mouth X-ray? ______________
3. Name and Address of former Dentist: ______________________________

______________________________

**XII. CHECK THE APPROPRIATE ANSWER:**

1. Do you experience sensitivity to:

   Hot? ☐ Cold? ☐ Sweets? ☐

| | YES | NO | |
|---|---|---|---|
| 2. | ☐ | ☐ | Have you ever had an injury to your face, neck or jaw? If yes, please explain: ______________ |

| | YES | NO | | | YES | NO | |
|---|---|---|---|---|---|---|---|
| 3. | ☐ | ☐ | Do you grind your teeth? | 4. | ☐ | ☐ | Have you ever had “clicking” or “popping” in your ears when chew? |
| 5. | ☐ | ☐ | Do your gums bleed? | 6. | ☐ | ☐ | Have you had gum (periodontal) surgery? |
| 7. | ☐ | ☐ | Have you had an unfavorable experience from local anesthetics? | 8. | ☐ | ☐ | Have you had orthodontic appliances (braces)? |
| 9. | ☐ | ☐ | Is there anything you would like to discuss in private with the Doctor? | | | | ______________________________ |

XIII. SECURITY

1. What is your Mother's Maiden Name? ______________________________

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.

Patient signature: ______________________________ Date: ________
(print) (sign)

CONSENT

I confirm as true the above health information. I hereby authorize the dentist to take x-rays, study models, photographs, or any aids deemed appropriate by the dentist in charge of my care to make a thorough diagnosis of my dental needs. I also authorize the dentist to perform any and all forms of treatment, medication and therapy that may be necessary for my dental health.

Signature: ______________________________ Date: ________
(print) (sign)