PATIENT INFORMATION

Advanta Dental Group
Family Dentistry and Cosmetic Dentistry

THIS INFORMATION IS NECESSARY FOR OUR FILES AND WILL BE CONSIDERED **CONFIDENTIAL.**

DATE _____

PATIENT'S NAME _____ (LAST / FIRST / INITIAL) AGE ____ BIRTH DATE _____

IF PATIENT IS A MINOR, GIVE PARENT'S OR GUARDIAN'S NAME _____ RELATIONSHIP _____

RESIDENCE ADDRESS _____ (STREET / CITY / ZIP)

PATIENT IS MALE FEMALE MINOR

DRIVER'S LICENSE NO. _____ SOCIAL SECURITY NO. _____ RES. PHONE ( ) _____

EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____ (STREET / CITY / ZIP) BUS. PHONE ( ) _____

SPOUSE'S NAME _____ DRIVER'S LIC. NO. _____ SOC. SEC. NO. _____

BUSINESS ADDRESS _____ (STREET / CITY / ZIP) BUS. PHONE ( ) _____

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____ RELATIONSHIP _____

COMPLETE ADDRESS _____ (STREET / CITY / ZIP) RES. PHONE ( ) _____

NAME OF PHYSICIAN _____ (ADDRESS / CITY / TELEPHONE)

FORMER DENTIST _____ (ADDRESS / CITY / TELEPHONE)

WHOM MAY WE THANK FOR REFERRING YOU? _____

HEALTH HISTORY

THESE QUESTIONS ARE FOR YOUR BENEFIT AND ASSURE THAT TREATMENT WILL TAKE INTO CONSIDERATION YOUR PAST AND PRESENT HEALTH STATUS. SOME QUESTIONS MAY SEEM UNRELATED TO YOUR DENTAL CONDITION, BUT THEY ARE ALL ASSOCIATED WITH PROPER ORAL HEALTH CARE.

PLEASE ANSWER EACH QUESTION. CIRCLE YES OR NO WHERE APPLICABLE.

MEDICAL HISTORY

1. ARE YOU IN GOOD HEALTH? ..... YES NO
2. DATE OF LAST PHYSICAL EXAMINATION _____
3. ARE YOU UNDER THE CARE OF A PHYSICIAN? ..... YES NO
   IF SO, WHAT IS THE CONDITION BEING TREATED _____
4. HAVE YOU EVER HAD ANY SERIOUS ILLNESS OR OPERATION? ..... YES NO
   IF SO, WHAT ILLNESS OR OPERATION? _____
5. HAVE YOU EVER BEEN HOSPITALIZED? ..... YES NO
   IF SO, WHAT WAS THE PROBLEM? _____
6. ARE YOU TAKING ANY DRUGS OR MEDICINE? ..... YES NO
   IF SO, WHAT? _____ WHAT DOSAGE? _____
7. ARE YOU SENSITIVE OR ALLERGIC TO ANY DRUGS? PENICILLIN TETRACYCLINE SULFA DRUGS ASPIRIN CODEINE OTHER IF OTHER, WHAT DRUGS? _____
8. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING (PLEASE √ KNOWN CONDITIONS) ..... YES NO

___ ANEMIA	___ HEMOPHILIA	___ DRUG ADDICTION	___ TUMORS OR GROWTHS	___ EPILEPSY OR SEIZURES	___ RADIATION TREATMENT OF ANY KIND
___ HERPES	___ RHEUMATISM	___ KIDNEY DISEASE	___ ALLERGIES OR HIVES	___ ARTIFICIAL PROSTHESIS	___ HEPATITIS OR JAUNDICE
___ STROKE	___ HEART MURMUR	___ STOMACH ULCERS	___ CORTISONE MEDICINE	___ PSYCHIATRIC TREATMENT	___ VENEREAL DISEASE (SYPHILIS GONORRHEA)
___ ULCERS	___ BRUISE EASILY	___ ANGINA PECTORIS	___ EXCESSIVE BLEEDING	___ CONGENITAL HEART LESIONS	___ ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)
___ DIABETES	___ HEAD INJURIES	___ MENTAL DISORDER	___ ASTHMA	___ DIFFICULTY IN SWALLOWING	___ PHEN PHEN
___ GLAUCOMA	___ HEART FAILURE	___ RHEUMATIC FEVER	___ HIGH BLOOD PRESSURE	___ HEART AILMENTS OR ATTACK	___ OTHER
___ ARTHRITIS	___ LIVER DISEASE	___ THYROID DISEASE	___ AIDS RELATED COMPLEX	___ X-RAY OR COBALL TREATMENT	
___ EMPHYSEMA	___ SCARLET FEVER	___ CEREBRAL PALSY	___ PAIN IN JAW JOINTS		
___ HAY FEVER	___ CHICKEN POX	___ BLOOD TRANSFUSION	___ RESPIRATORY DISEASE	___ FAINTING SPELLS OR SEIZURES	
___ TONSILLITIS	___ SINUS TROUBLE	___ JOINT REPLACEMENT	___ SICKLE CELL DISEASE	___ CHEMOTHERAPY (CANCER, LEUKEMIA)	
___ COLD SORES	___ BLOOD DISEASE	___ NERVOUS DISORDERS	___ TUBERCULOSIS (TB)		

9. DO YOU WEAR A CARDIAC PACEMAKER, OR HAVE YOU HAD HEART SURGERY? ..... YES NO
10. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED THAT YOU THINK I SHOULD KNOW ABOUT? ..... YES NO
    IF SO, WHAT? _____
11. (WOMAN) ARE YOU PREGNANT? IF SO, HOW MANY MONTHS? _____
12. (WOMAN) DO YOU HAVE ANY PROBLEMS ASSOCIATED WITH YOUR MENSTRUAL PERIOD? ..... YES NO
13. (WOMAN DO YOU TAKE BIRTH CONTROL PILLS? ..... YES NO

DENTAL HISTORY

1 HAVE YOU EVER HAD A LOCAL ANESTHETIC (NOVOCAINE, ETC.)? ..... YES NO

2. HAVE YOU EVER HAD ANY UNFAVORABLE REACTION FROM A LOCAL ANESTHETIC? ..... YES NO

3. HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WITH ANY PREVIOUS DENTAL TREATMENT? ..... YES NO

IF SO EXPLAIN _____

4. HOW LONG SINCE YOUR LAST FULL MOUTH X-RAYS? _____

5. HOW LONG SINCE YOUR LAST DENTAL TREATMENT? _____

6. DOES DENTAL TREATMENT MAKE YOU NERVOUS? ..... YES NO

IF YES, CHECK ✓ SLIGHTLY MODERATELY EXTREMELY

7. WOULD YOU DESIRE TO BE PRE-SEDATED? ..... YES NO

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH OR IF MY MEDICATIONS CHANGE, I WILL, WITHOUT FAIL, INFORM THE DOCTOR AT MY NEXT APPOINTMENT.

DATE _____ SIGNATURE _____

YEAR 2

CHANGES IN HEALTH _____

DATE _____ SIGNATURE _____

YEAR 3

CHANGES IN HEALTH _____

DATE _____ SIGNATURE _____

HEALTH QUESTIONNAIRE MUST BE UPDATED EACH YEAR!

REVIEWED BY

YEAR 1 _____

YEAR 2 _____

YEAR 3 _____

DO NOT WRITE IN THIS SPACE

	YEAR 1	YEAR 2	YEAR 3
DATE			
BP			
PULSE			
TEMP			
BY			

FINANCIAL INFORMATION

DO YOU HAVE DENTAL INSURANCE? YES NO

NAME OF INSURANCE COMPANY

ADDRESS OF INSURANCE COMPANY

POLICY # LOCAL # BIRTH DATE

NAME OF INSURED

SOCIAL SECURITY #

DO YOU HAVE A SECOND PLAN? YES NO

NAME OF INSURANCE COMPANY

ADDRESS OF INSURANCE COMPANY

POLICY # LOCAL# BIRTH DATE

NAME OF INSURED

SOCIAL SECURITY #

CONSENT FOR TREATMENT

The above health history is complete and correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between Doctor and Patient and/or Guardian to be necessary or advisable, including the use of local anesthesia and other medication as indicated. I agree that, regardless of insurance coverage, I am responsible for payment of services rendered and that a finance charge of 1 1 2 % will be applied to accounts past sixty days.

Signature of Patient, Parent, or Guardian

Date