

**ADULT
CONFIDENTIAL PATIENT INFORMATION**

PLAZA DENTAL CARE LLC

Personal Information

Date _____

Name: _____ Preferred Name: _____ Date of Birth _____

Address: _____
(If P.O. Box, please include street address) Street City State Zip

Telephone: Home: _____ Business: _____ Cell: _____

Employer: _____ SS # _____ Email _____

Name of Spouse: _____ Name of Children: _____

Referred by: _____, we would like to thank them. Family Co-Worker
 Neighbor Insurance Phone Book Newspaper Welcome Wagon Other _____

Person Responsible for Account (if other than patient)

Name: _____ Relationship: _____ S.S. # _____

Address: _____
Street City State Zip

Telephone: Home: _____ Business: _____ Cell: _____

I will be responsible for payment of the services furnished and agree to pay for such treatment regardless of insurance or any other third party involvement. I also agree, if the need arises for my account to be referred to collection, to pay all agency fees, court costs, attorney's and legal fees.

Signature _____ Date _____

Dental Insurance Information

Primary Insurance Co.: _____

Employee: _____ Relationship: _____ S.S. # _____

Employer: _____ Policy Number _____

Employee's Date of Birth: _____

Secondary Insurance Co.: _____

Employee: _____ Relationship: _____ S.S. # _____

Employer: _____ Policy Number _____

Employee's Date of Birth: _____

(OVER)

Dental and Oral Health Information

Please describe any specific dental problem or discomfort you are having at this time: _____

_____ How long has it been present? _____

If you have had any of the following dental care, please list the dentists and approximate dates:

Periodontal (gum) treatment or surgery: _____

"Braces" or any type of orthodontic treatment: _____

Dental Implants: _____

Any other type of oral surgery: _____

Do you have / have you had / have you noticed any of the following signs or symptoms in your head, neck or mouth?

(Please check Yes or No for each question)	Yes	No		Yes	No
Teeth that are sensitive to:					
Hot, cold, sweets, or biting pressure	_____	_____	A clicking, snapping or difficulty when chewing	_____	_____
An unpleasant taste or persistent bad breath	_____	_____	Difficulty opening or moving the jaws	_____	_____
Does food catch between your teeth	_____	_____	Difficulty speaking or changes in your voice	_____	_____
Do your gums bleed when brushing	_____	_____	Difficulty moving your tongue or "tongue tied"	_____	_____
Red, swollen, tender, bleeding or sore gums	_____	_____	Loose or separating teeth	_____	_____
Gums that have pulled away from the teeth	_____	_____	Changes in the way your teeth fit together	_____	_____
Pus between the teeth and gums	_____	_____	A color change of the tissues in your mouth	_____	_____
Avoid any area when brushing or chewing	_____	_____	Pain, tenderness, numbness, or earaches	_____	_____
You clench or grind your teeth	_____	_____	Any lumps, swelling or swollen glands	_____	_____
			Sores, ulcers, or rough spots in your mouth	_____	_____

Your Dental Health:

How do you rate your overall dental health?

Good Fair Poor

How many times a day do you brush your teeth? _____

How many times a week do you floss your teeth? _____

Do you use any of the following? (Please check Yes or No for each question)

Yes No

Mechanical (electric) toothbrush	_____	_____	If Yes, what type or brand? _____	_____	_____
Flossing aids (floss holders, threaders, etc.)	_____	_____		_____	_____
Oral irrigating device (Waterpik)	_____	_____		_____	_____
Fluoride treatments or supplements at home. If Yes, which ones:	_____	_____	_____	_____	_____
Mouthwashes or oral rinses. If Yes, what brand?	_____	_____	_____	_____	_____

Do you have any missing teeth that have not been replaced?

_____ _____

Why have you not had them replaced? _____

Do you wear any removable dental appliances?

_____ _____

If Yes, what type and for how long? _____

Have you ever had your teeth whitened or bleached?

_____ _____

Would you like to have your teeth whitened or bleached?

_____ _____

How do you feel about the appearance of your smile and what would you change if you could?

Are you frustrated because you always need something treated or repaired when you visit a dentist?

_____ _____

Do you feel you will eventually wear artificial dentures?

_____ _____

Have you ever had any complications from an extraction or dental treatment?

_____ _____

If Yes, please explain _____

Have you ever had any other dental conditions, major trauma or injury to your head, neck or mouth?

_____ _____

If Yes, please explain _____

If you are a new patient to this practice:

Date of last dental visit _____ Dentist's Name _____ City & State _____

Health Information and History

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

If you are completing this form for another person:

Your name: _____ Phone: _____ Relationship: _____

Emergency Contact: (If not listed below)

Name: _____ Phone: _____ Relationship: _____

Primary Physician: _____ Phone: _____ City & State: _____

Date of last physical examination: _____ Date of last blood test/work up: _____

Other Physicians & Specialists:

Name: _____ Specialty: _____ Phone: _____ City & State: _____

Name: _____ Specialty: _____ Phone: _____ City & State: _____

1. Within the last 3 years, have you been hospitalized or had surgery? Yes No

If Yes, please give reasons and dates: _____

2. Have you ever been instructed to take ANY medication or take ANY special precautions before any dental appointments? Yes No

If Yes, please explain: _____

3. Are you taking ANY drugs, medications or treatments at this time? Yes No
(If you brought a complete written list with you, give that to the receptionist instead.)

Prescribed: _____

Over-the-counter (OTC) medications (such as aspirin, Advil, allergy medications, sleeping aids, etc.):

Are you having or ever had radiation or chemotherapy treatments? Yes No

If Yes, for how long? _____ Name of facility performing the treatment: _____

4. Are you taking or have you ever taken / been treated for osteoporosis with a Bisphosphonate (Fosamax, Boniva, Actonel, Reclast) or any other drug? Yes No

How long have you been taking this medication? _____

5. Are you allergic to or have you ever experienced an unusual reaction to:

____ Latex ____ Metals or jewelry ____ Dental anesthesia (local)
____ Fluoride ____ Nitrous oxide (laughing gas) ____ General anesthesia

6. Are you allergic to or have you ever had any reaction to any of the following drugs?

____ Penicillin (or related drugs) ____ Tranquilizers (Valium) ____ Tetra cycline ____ Codeine
____ Aspirin / Ibuprofen (Advil, Motrin, Nuprin) ____ Keflex (Cephalexin) ____ Sulfa Drugs ____ Iodine
____ NSAID (Celebrex, Vioxx, Anaprox) ____ Clindamycin (Cleocin) ____ Erythromycin

7. Have you ever had an allergic reaction or unusual response to ANY other medications, drugs, pills, or treatments? Yes No

If Yes, please list: _____

(OVER)

8. Do you have or have you ever had any of the following? (Please check Yes or No for each question)

	Yes	No		Yes	No
Congenital heart defects	_____	_____	Asthma	_____	_____
Angina or chest pains	_____	_____	Do you use an inhaler?	_____	_____
Atherosclerosis	_____	_____	Hay fever, skin or food allergies	_____	_____
Congestive heart failure	_____	_____	Sinus problems	_____	_____
Coronary artery disease	_____	_____	Tuberculosis, emphysema or lung disorder	_____	_____
Heart Surgery	_____	_____	Skin problems	_____	_____
If Yes, type & date _____			A sore or wound that bleeds easily or does not heal	_____	_____
Heart Attack	_____	_____	A thyroid problem or disease	_____	_____
If Yes, date _____			Arthritis	_____	_____
Rheumatic heart disease / rheumatic fever	_____	_____	Glaucoma or any eye disease	_____	_____
Infective Endocarditis	_____	_____	Epilepsy or other seizure disorder	_____	_____
Heart valve(s) damage / Mitral valve prolapse	_____	_____	Any kidney problems	_____	_____
Artificial heart valve	_____	_____	Ulcers, acid reflux, or stomach problems	_____	_____
Pacemaker	_____	_____	A compromised immune system (Lupus, HIV, AIDS, radiation immune problem, etc.)	_____	_____
Stroke or CVA	_____	_____	Sexually transmitted disease (STD)	_____	_____
High blood pressure	_____	_____	Any mental health issues	_____	_____
Low blood pressure	_____	_____			
Anemia	_____	_____	Women Only:	Yes	No
Hemophilia or bleeding disorder	_____	_____	Are you pregnant?	_____	_____
Excessive bleeding from any cut or incident	_____	_____	If Yes, what is your due date? _____		
Diabetes or blood sugar problems	_____	_____	Do you think you might be pregnant?	_____	_____
A1C Level _____			Are you presently nursing?	_____	_____
Any artificial joint, joint surgery or prosthesis	_____	_____	Are you using birth control medication?	_____	_____
If Yes, what joint or area: _____			Are you taking hormone replacement therapy?	_____	_____
When was operation done? _____					
Hepatitis, jaundice, or other liver problems	_____	_____			
Any form of cancer	_____	_____			

9. Do you have any other conditions, diseases or medical problems, or is there ANY other information that you would like us to know about, or that we should be made aware of? Yes No

If Yes, please explain: _____

CONSENT: To the best of my knowledge, all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the charges without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice.

I understand there are no guarantees or warranties in health or dental care.

Signature _____ Date _____
 (Parent or guardian, if patient is a minor)