Patient Information Form

Today's Date_____

Name _____
What do you prefer to be called?
_____
Address _____
_____
City _____
State _____ Zip Code _____
Social Security # _____
Date of Birth _____
Employer _____

Email Address _____
Spouse Name _____
Spouse D.O.B. _____
Spouse Phone _____
Spouse Email _____
Best way to contact you _____
Home Phone _____
Work Phone _____
Cell Phone _____
Male ___ Female ___

Dental Insurance

Carrier _____
Policy Holder _____
Date of birth if not patient _____

Employer of policy holder
_____
Membership # _____
Group # _____

Dental History

Name of previous Dentist _____
Date of last visit _____

Whom may we thank for referring you?
_____

	Yes	No
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot or cold?	☐	☐
Are your teeth sensitive to sweet or sour?	☐	☐
Do you feel pain in any of your teeth?	☐	☐
Do you have any sores or lumps near your mouth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐

	Yes	No
Do you have difficulty in opening, closing or chewing?	☐	☐
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks?	☐	☐
Have you ever had difficult extractions?	☐	☐
Have you ever had prolonged bleeding following extractions?	☐	☐

	Yes	No
Have you ever had orthodontic treatment?	☐	☐
Do you wear dentures or partials?	☐	☐
Have you ever received oral hygiene instruction regarding your teeth and gums?	☐	☐
Do you like your smile?	☐	☐
Have you experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain	☐	☐
Difficulty in opening, closing or chewing	☐	☐

Medical History

Name of Physician _____
Physician's Phone Number _____
Date of Last Visit _____

	Yes	No
Is there anything you would like to speak to the doctor about privately?	☐	☐
Are you currently taking any prescription or non-prescription medications?	☐	☐
Please list all medications _____		
_____		
Are you under medical treatment now?	☐	☐
If so, for what _____		
Have you been hospitalized in the last 5 years?	☐	☐
If so, for what _____		
Are you taking any type of blood thinners?	☐	☐
If so, for what _____		

	Yes	No
Have you ever taken Fosamax, Boniva, Actonel or any cancer medication containing bisphosphonates?	☐	☐
Have you taken Viagra, Revati, Cialis or Levita in the past 24 hours?	☐	☐
Do you use tobacco?	☐	☐
Do you use any controlled substances?	☐	☐
Do you have a persistent cough or throat clearing not associated with a known illness?	☐	☐

Women, please answer the following;

Are you pregnant or think you may be?	☐	☐
Are you nursing?	☐	☐
Are you taking any contraceptives?	☐	☐

Are you allergic to or ever had a reaction to any of the following:

	Yes	No
Iodine	☐	☐
Latex Rubber	☐	☐
Aspirin	☐	☐
Any Metals	☐	☐
Sedatives	☐	☐
Local Anesthetics (ex. Novacaine)	☐	☐
Penicillin or any other antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Other _____		

Do you have or have you had any of the following? (Please Check)

	Yes	No		Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	AIDS or HIV Infection	☐	☐	Arthritis	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Thyroid Problem	☐	☐	Joint Replacement or Implant	☐	☐	Glaucoma	☐	☐
Heart Attack	☐	☐	Heart Disease	☐	☐	Hepatitis/Jaundice	☐	☐	Recent Weight Loss	☐	☐
Rheumatic Fever	☐	☐	Cardiac Pacemaker	☐	☐	Sexually Transmitted Disease	☐	☐	Liver Disease	☐	☐
Swollen Ankles	☐	☐	Heart Murmur	☐	☐	Stomach Troubles or Ulcers	☐	☐	Heart Trouble	☐	☐
Fainting/Seizures	☐	☐	Angina	☐	☐	Chest Pains	☐	☐	Respiratory Problems	☐	☐
Asthma	☐	☐	Fatigue	☐	☐	Easily Winded	☐	☐	Mitral Valve Prolapse	☐	☐
Epilepsy/Convulsions	☐	☐	Anemia	☐	☐	Stroke	☐	☐	Other _____		
Diabetes	☐	☐	Emphysema	☐	☐	Hay Fever/Allergies	☐	☐	_____		
Kidney Disease	☐	☐	Cancer	☐	☐	Tuberculosis	☐	☐	_____		

INSURANCE: As a courtesy, our office will fill out the necessary forms and submit to your insurance company . We do, however, consider each patient responsible for their entire account. We do our best to assist you.

If you have any questions regarding your treatment or fees, we will be happy to discuss them with you. Should you have any concern between visits or after completion of your treatment, please do not hesitate to call.

The information on these pages are correct to the best of my knowledge. 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. I certify to the above statements regarding my medical condition.

For your convenience, we offer the following types of payment:
☐ Cash ☐ Personal Check ☐ Credit Card: ☐ Visa ☐ Master Card ☐ I wish to discuss the office's payment policy

Signature of patient _____ Date _____

Signature of parent or legal guardian if under 18 years of age _____

In Case of Emergency, Please Contact

Name _____
Address _____
_____
Phone _____

LEIGH FAMILY & COSMETIC DENTISTRY

Signature of doctor _____ Date _____