

Town Center Dentistry and Orthodontics

Patient Information Sheet

Whom may we thank for referring you to our dental and orthodontic practice? _____

Name _____ Married Single Minor
Last First MI

Address _____ Date of Birth ____/____/____
Street Apt. # City State Zip Month Day Year

Telephone Home: () _____ - _____ Work: () _____ - _____ E-Mail _____

Place of Employment _____ Dental Insurance Co. _____

Group # _____ If Full Time Student, Name of School _____

Has any member of your family been treated in our practice? Yes No

Insured Information

Acknowledgement and Authority

Primary

Name: Last First MI

Address: Street City State Zip

Home Telephone # Work Telephone #

Date of Birth SS#

Employer Group #

Dental Insurance Co. Insurance Telephone #

x

Secondary

Name: Last First MI

Address: Street City State Zip

Home Telephone # Work Telephone #

Date of Birth SS#

Employer Group #

Dental Insurance Co. Insurance Telephone #

- The Information on this page and the dental/medical histories are correct to the best of my knowledge.
- I hereby authorize the Dentist to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.
- I grant the right to the dentist to release my dental/medical and other information about my dental treatment to third party payers and/or other health professionals, as appropriate under the circumstances.
- I also acknowledge full responsibility for the payment of fees for such services and agree to pay for them, in full, AT THE TIME OF SERVICE, unless other arrangement have been made in writing with a practice representative.
- I have received a copy of the HIPAA Privacy Policy as required by law.
- I grant the dental office permission to use the email address given above to contact me with respect to my dental care.

Adult Pt. Father/ Mother Guardian

Person to Contact in Case of Emergency

Name _____

Address _____

Telephone # (____) _____ - _____

Patient Health Information

Name: _____

Date: _____

Physician's Name: _____

Date Last Seen: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Have you ever had any surgical procedures? Yes No

Please list each one: _____

Are you taking any medications? Yes No

Please list each one: _____

Do you use tobacco in any form?: Yes No

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition																		
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	HIV+ Aids	<input type="checkbox"/>	<input type="checkbox"/>	Stroke																		
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack: When? _____	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems																		
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis																		
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<table border="0"> <thead> <tr> <th>Yes</th> <th>No</th> <th>Allergies</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Aspirin</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Codeine</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Latex</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Penicillin</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Tetracycline</td> </tr> </tbody> </table>			Yes	No	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline
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<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C																					
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure																					
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement																					
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems																					
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease																					
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<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Seizures																					
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease																					
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems																					

Is there any other disease/condition not listed above? _____

Please check if you have had or have any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Clicking/popping of jaw | <input type="checkbox"/> Loose teeth |
| <input type="checkbox"/> Bad tastes | <input type="checkbox"/> Difficulty chewing | <input type="checkbox"/> Mouth sores |
| <input type="checkbox"/> Bite nails/objects | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Missing teeth |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Gag easily | <input type="checkbox"/> Sensitive gums |
| <input type="checkbox"/> Chew on one side | <input type="checkbox"/> Infection in gums | <input type="checkbox"/> Sensitive to: <input type="checkbox"/> Hot <input type="checkbox"/> Cold <input type="checkbox"/> Sweets |
| <input type="checkbox"/> Clenching/grinding teeth | <input type="checkbox"/> Jaw pain/soreness | <input type="checkbox"/> Stained teeth |

I understand that the information that I have given today is the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status.

Signature: _____

Date: _____

Medical History Update

Date: _____ Changes: _____ None Signature: _____

Date: _____ Changes: _____ None Signature: _____

Date: _____ Changes: _____ None Signature: _____