

# Exquisite Dental Care, PC

## PATIENT INFORMATION

The following information will make it possible for us to be more successful and thorough in your treatment. Your answers are for our records only and considered confidential.

### Personal Information:

\_\_\_\_\_  
Last Name First MI Nickname Date  
Home Address: \_\_\_\_\_ Home Phone:(\_\_\_\_\_) \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Cell Phone:(\_\_\_\_\_) \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Work Phone:(\_\_\_\_\_) \_\_\_\_\_  
Sex: M  F  Marital Status: S  M  D  W  Social Security #: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Referring Dentist: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Person Responsible for Payment of Account (if other than self): \_\_\_\_\_  
Address: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number:(\_\_\_\_\_) \_\_\_\_\_

### Emergency Contact Information:

Name: \_\_\_\_\_ Home Phone:(\_\_\_\_\_) \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Work Phone:(\_\_\_\_\_) \_\_\_\_\_

### Dental Insurance Information:

Subscriber's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Subscriber's ID #: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_  
Subscriber's Employer: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Insurance Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number:(\_\_\_\_\_) \_\_\_\_\_

### Medical/Dental History:

Medical Physician's Name: \_\_\_\_\_ Phone Number:(\_\_\_\_\_) \_\_\_\_\_  
Reason for Last Exam: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

### Are you being treated for any of the following?

YES <input type="checkbox"/>	NO <input type="checkbox"/>	AIDS/HIV	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Cortisone Treatments
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Abnormal Bleeding	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Cough, Persistent or Bloody
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Anaphylaxis	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Diabetes, Type _____
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Anemia (Sickle Cell Anemia)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Drug or Alcohol Addiction
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Arthritis	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Emphysema
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Artificial Heart Values	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Epilepsy
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Artificial Joints	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Fainting/Dizziness
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Asthma	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Glaucoma
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Back Problems	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Headaches
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Bladder Troubles	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Heart Murmur
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Blood Disease	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Heart Problems
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Cancer	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Hemophilia
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Chest Pain	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Hepatitis, Type: _____
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Circulatory Problems	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Herpes
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Cold Sores, Blisters	YES <input type="checkbox"/>	NO <input type="checkbox"/>	High/Low Blood Pressure
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Congenital Heart Failure	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Jaw Pain

- |  |                          |  |                           |
|--|--------------------------|--|---------------------------|
| YES <input type="checkbox"/> NO <input type="checkbox"/> | Kidney Disease           | YES <input type="checkbox"/> NO <input type="checkbox"/> | Sinus Trouble             |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | Liver Disease            | YES <input type="checkbox"/> NO <input type="checkbox"/> | Skin Rash                 |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | Mitral Valve Prolapse    | YES <input type="checkbox"/> NO <input type="checkbox"/> | Spine Bifida              |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | Nervous Problems         | YES <input type="checkbox"/> NO <input type="checkbox"/> | STD                       |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | Pacemaker                | YES <input type="checkbox"/> NO <input type="checkbox"/> | Stroke                    |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | Pre-Med with Antibiotics | YES <input type="checkbox"/> NO <input type="checkbox"/> | Swollen Feet or Ankles    |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | Psychiatric Care         | YES <input type="checkbox"/> NO <input type="checkbox"/> | Swollen Neck Glands       |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | Radiation Treatment      | YES <input type="checkbox"/> NO <input type="checkbox"/> | Thyroid Problems          |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | Respiratory Disease      | YES <input type="checkbox"/> NO <input type="checkbox"/> | Tonsillitis               |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | Rheumatic/Scarlet Fever  | YES <input type="checkbox"/> NO <input type="checkbox"/> | Tuberculosis              |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | Shortness of Breath      | YES <input type="checkbox"/> NO <input type="checkbox"/> | Tumor/Growth on Head/Neck |
|  |                          | YES <input type="checkbox"/> NO <input type="checkbox"/> | Ulcers                    |
|  |                          | YES <input type="checkbox"/> NO <input type="checkbox"/> | Weight Loss, unexplained  |
|  |                          | YES <input type="checkbox"/> NO <input type="checkbox"/> | Other: _____              |

YES  NO  Are you being treated by a medical doctor now? If yes, why? \_\_\_\_\_

YES  NO  Are you taking any medication at the present time? If yes, please list: \_\_\_\_\_

\_\_\_\_\_

YES  NO  Do you have any known **ALLERGIES** at the present time? If yes, please list: \_\_\_\_\_

\_\_\_\_\_

YES  NO  Have you ever had any surgical operations or ever been hospitalized? If yes, please list reasons and dates: \_\_\_\_\_

YES  NO  Have you ever had a blood transfusion? If yes, please give reason(s): \_\_\_\_\_

YES  NO  Have you had any serious trouble associated with any previous dental treatment? If yes, Please explain: \_\_\_\_\_

YES  NO  Have you recently had dental x-rays? If yes, when? \_\_\_\_\_

YES  NO  Do you clench or grind your teeth?

YES  NO  Are any of your teeth sensitive to cold or sweets?

YES  NO  Have you had excessive swelling, pain, or excessive bleeding after oral surgery?

YES  NO  Do you have your teeth cleaned on a regular basis? If yes, how often: every \_\_\_\_\_

YES  NO  Do you have bleeding gums or a bad taste in your mouth?

YES  NO  Does your jaw click or pop when you chew?

YES  NO  Have you ever received treatment for periodontal disease?

YES  NO  Do you use tobacco? If yes, **what type** and **how much** per day? \_\_\_\_\_

YES  NO  Do you wish to talk to the doctor privately about any problem?

For Females Only:

YES  NO  Are you pregnant? If yes, what is your due date? \_\_\_\_\_

YES  NO  Are you nursing?

YES  NO  Are you taking birth control pills?

**TO THE BEST OF MY KNOWLEDGE ALL OF THE ABOVE ANSWERS ARE TRUE AND CORRECT, IF I HAVE ANY CHANGES IN MY HEALTH; I WILL INFORM THE STAFF BY MY NEXT APPOINTMENT.**

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date