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

YES ☐ NO ☐ Kidney Disease
YES ☐ NO ☐ Liver Disease
YES ☐ NO ☐ Mitral Valve Prolapse
YES ☐ NO ☐ Nervous Problems
YES ☐ NO ☐ Pacemaker
YES ☐ NO ☐ Pre-Med with Antibiotics
YES ☐ NO ☐ Psychiatric Care
YES ☐ NO ☐ Radiation Treatment
YES ☐ NO ☐ Respiratory Disease
YES ☐ NO ☐ Rheumatic/Scarlet Fever
YES ☐ NO ☐ Shortness of Breath

YES ☐ NO ☐ Sinus Trouble
YES ☐ NO ☐ Skin Rash
YES ☐ NO ☐ Spine Bifida
YES ☐ NO ☐ STD
YES ☐ NO ☐ Stroke
YES ☐ NO ☐ Swollen Feet or Ankles
YES ☐ NO ☐ Swollen Neck Glands
YES ☐ NO ☐ Thyroid Problems
YES ☐ NO ☐ Tonsillitis
YES ☐ NO ☐ Tuberculosis
YES ☐ NO ☐ Tumor/Growth on Head/Neck
YES ☐ NO ☐ Ulcers
YES ☐ NO ☐ Weight Loss, unexplained
YES ☐ NO ☐ 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**