

Interlachen Dental Associates Patient Information and History

Patient Information :

Date: _____

SS#: _____ Birth date: _____

Last name : _____

First name/Middle initial: _____

Address: _____

City/State/ZIP: _____

E-mail: _____

Sex M F Age: _____

Married Widowed Single
 Separated Divorced Minor

Patient Employer/School: _____

Occupation: _____

Employer/School Address: _____

Employer/School Phone: _____

Spouse's name: _____

Spouse's SS#: _____

Spouse's Birth date: _____

Spouse's Employer: _____

Whom may we thank for referring you?

Who is responsible for this account?

Relationship to patient: _____

Insurance Co.: _____

Group #: _____

Is patient covered by additional insurance? Yes No

Subscriber's Name: _____

SS#: _____ Birth date: _____

Relationship to patient: _____

Insurance Co.: _____

Group #: _____

Assignment and Release

I certify that I, and/or my dependent(s) have insurance coverage with _____ (name of insurance company) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-name dentist may use my health care information and may disclose such information to the above-name insurance company or companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Phone Numbers:

Home: _____ Work: _____ ext. _____

Cell phone: _____ Spouse's work: _____

Best time and place to reach you? _____

In case of emergency contact (Specify someone who does not live in your household.):

Name: _____ Relationship: _____

Home phone: _____ Work phone: _____

Dental History

Reason for today's visit: _____

Former dentist: _____ City/ State: _____

Date of last dental visit: _____ Date of last dental z-rays: _____

Place a mark on *yes* or *no* to indicate if you have had any of the following:

Bad breath	<input type="checkbox"/> yes <input type="checkbox"/> no	Burning sensation on tongue	<input type="checkbox"/> yes <input type="checkbox"/> no	Mouth breathing	<input type="checkbox"/> yes <input type="checkbox"/> no
Bleeding gums	<input type="checkbox"/> yes <input type="checkbox"/> no	Chew on one side of mouth	<input type="checkbox"/> yes <input type="checkbox"/> no	Mouth pain, brushing	<input type="checkbox"/> yes <input type="checkbox"/> no
Blisters on lips	<input type="checkbox"/> yes <input type="checkbox"/> no	Tobacco use	<input type="checkbox"/> yes <input type="checkbox"/> no	Orthodontics	<input type="checkbox"/> yes <input type="checkbox"/> no
Dry mouth	<input type="checkbox"/> yes <input type="checkbox"/> no	Fingernail biting	<input type="checkbox"/> yes <input type="checkbox"/> no	Pain around ear	<input type="checkbox"/> yes <input type="checkbox"/> no
Grinding teeth	<input type="checkbox"/> yes <input type="checkbox"/> no	Gums swollen or tender	<input type="checkbox"/> yes <input type="checkbox"/> no	Jaw pain or tiredness	<input type="checkbox"/> yes <input type="checkbox"/> no
Loose teeth	<input type="checkbox"/> yes <input type="checkbox"/> no	Broken fillings	<input type="checkbox"/> yes <input type="checkbox"/> no	Lip or cheek biting	<input type="checkbox"/> yes <input type="checkbox"/> no

How often do you floss?

How often do you brush?

Health History

Physician's name: _____ Date of last visit: _____

Place a mark on *yes* or *no* to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> yes <input type="checkbox"/> no	Epilepsy	<input type="checkbox"/> yes <input type="checkbox"/> no	Respiratory Disease	<input type="checkbox"/> yes <input type="checkbox"/> no
Anemia	<input type="checkbox"/> yes <input type="checkbox"/> no	Fainting or dizziness	<input type="checkbox"/> yes <input type="checkbox"/> no	Rheumatic Fever	<input type="checkbox"/> yes <input type="checkbox"/> no
Arthritis, Rheumatism	<input type="checkbox"/> yes <input type="checkbox"/> no	Glaucoma	<input type="checkbox"/> yes <input type="checkbox"/> no	Scarlet Fever	<input type="checkbox"/> yes <input type="checkbox"/> no
Artificial heart valves	<input type="checkbox"/> yes <input type="checkbox"/> no	Headaches	<input type="checkbox"/> yes <input type="checkbox"/> no	Shortness of breath	<input type="checkbox"/> yes <input type="checkbox"/> no
Asthma	<input type="checkbox"/> yes <input type="checkbox"/> no	Heart murmur	<input type="checkbox"/> yes <input type="checkbox"/> no	Sinus trouble	<input type="checkbox"/> yes <input type="checkbox"/> no
Back problems	<input type="checkbox"/> yes <input type="checkbox"/> no	Hepatitis Type _____	<input type="checkbox"/> yes <input type="checkbox"/> no	Skin rash	<input type="checkbox"/> yes <input type="checkbox"/> no
Bleeding abnormally,	<input type="checkbox"/> yes <input type="checkbox"/> no	High blood pressure	<input type="checkbox"/> yes <input type="checkbox"/> no	Swollen feet or ankles	<input type="checkbox"/> yes <input type="checkbox"/> no
With extractions of surgery					
Blood disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Jaundice	<input type="checkbox"/> yes <input type="checkbox"/> no	Swollen neck glands	<input type="checkbox"/> yes <input type="checkbox"/> no
Cancer	<input type="checkbox"/> yes <input type="checkbox"/> no	Jaw pain	<input type="checkbox"/> yes <input type="checkbox"/> no	Thyroid problems	<input type="checkbox"/> yes <input type="checkbox"/> no
Chemical dependency	<input type="checkbox"/> yes <input type="checkbox"/> no	Kidney disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Tonsillitis	<input type="checkbox"/> yes <input type="checkbox"/> no
Chemotherapy	<input type="checkbox"/> yes <input type="checkbox"/> no	Liver disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Tuberculosis	<input type="checkbox"/> yes <input type="checkbox"/> no
Circulatory problems	<input type="checkbox"/> yes <input type="checkbox"/> no	Low blood pressure	<input type="checkbox"/> yes <input type="checkbox"/> no	Tumor or growth on	<input type="checkbox"/> yes <input type="checkbox"/> no
Congenital heart lesions	<input type="checkbox"/> yes <input type="checkbox"/> no	Mitral valve prolapse	<input type="checkbox"/> yes <input type="checkbox"/> no	head or neck	
Cortisone treatment	<input type="checkbox"/> yes <input type="checkbox"/> no	Nervous problems	<input type="checkbox"/> yes <input type="checkbox"/> no	Ulcers	<input type="checkbox"/> yes <input type="checkbox"/> no
Cough, persistent	<input type="checkbox"/> yes <input type="checkbox"/> no	Pacemaker	<input type="checkbox"/> yes <input type="checkbox"/> no	Venereal disease	<input type="checkbox"/> yes <input type="checkbox"/> no
Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no	Psychiatric care	<input type="checkbox"/> yes <input type="checkbox"/> no	Weight loss,	<input type="checkbox"/> yes <input type="checkbox"/> no
Emphysema	<input type="checkbox"/> yes <input type="checkbox"/> no	Radiation treatment	<input type="checkbox"/> yes <input type="checkbox"/> no	unexplained	

Do you wear contact lenses? yes no

Women:

Are you pregnant yes no

Due date _____

Are you nursing? yes no

Taking birth control pills? yes no

Medications:

List any medications you are currently taking:

Do you take any herbal supplements? yes no

If yes, please list: _____

Allergies:

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local anesthetic
<input type="checkbox"/> Barbituates (sleeping pills)	<input type="checkbox"/> Codeine
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Iodine
<input type="checkbox"/> Sulfa	<input type="checkbox"/> Latex
<input type="checkbox"/> Other: _____	

Pharmacy name: _____

Phone: _____