PATIENT INFORMATION

Date _____

Name _____

Address _____

_____

Phone _____

Social Security _____

Age _____ Birth date _____

Sex _____ Marital Status _____

Referred by _____

Reason _____

Dentist's Name _____

Phone _____

Physician _____

Phone _____

Responsible Party _____

SS#_____ Birth date _____

Employer _____

Phone _____

Address _____

_____

Emergency Contact _____

Phone _____

I will be paying today by (circle one):

Cash Check Credit Card

Dental Insurance Company Name

_____

Address _____

_____

Phone _____

ID Number _____

Group Number _____

Insured's Name _____

Medical Insurance Company Name

_____

Address _____

_____

Phone _____

ID Number _____

Group Number _____

Insured's Name _____

PIP or Workers' Comp Insurance Company Name

_____

Address _____

_____

Phone _____

Claim Number _____

Adjuster _____

Date of Accident _____

I understand that I am financially responsible for all charges incurred for consultations or surgical services rendered. I agree, if applicable, if no reimbursement has been received from my insurer I shall be liable for all costs. I further agree that if my insurance company has not paid for my charges within two months of being filed, I will begin to pay for my medical charges.

_____

Signature of Patient **Date**

PATIENT INFORMATION

Review of Systems & Medical History **Patient** _____

The following information is needed for your general welfare whether you are here for a diagnostic consultation, a simple extraction or an oral surgical procedure.

Do you have any allergies? If so, please state them _____

_____

List any previous surgical procedures you have had _____

_____

Are you taking any medications? If so, please list them _____

_____

Do you take daily aspirin or other blood thinning medication? If so, please list _____

Have you had a PET scan? _____

Circle the number below if it applies to you:

1. Weight change
2. Fever
3. Night sweats
4. Thyroid disorder
5. Prior radiation therapy
6. Visual difficulties
7. Deafness
8. Dizziness
9. Nausea or vomiting
10. Heartburn
11. Abdominal pain
12. Yellow jaundice
13. Diabetes
14. Constipation
15. Hernia
16. Ulcer disease
17. Previous surgery
18. Alcohol consumption
19. Shortness of breath
20. Cough or phlegm
21. Coughing blood
22. Skin test positive for TEMP-BOND WITHOUT EUGENOL.
23. Fainting
24. Chest pain
25. Heart attack or failure
26. Swelling
27. High blood pressure
28. Birth control
29. Ever pregnant
30. Rash
31. Moles
32. Skin cancer
33. Headaches
34. Weak in any area
35. Excessively tired
36. Bleeding/bruising
37. Abnormal blood counts
38. Joint or muscle aches
39. Voice hoarseness
40. Pain
41. Loss of appetite
42. Previous dental extractions
43. Previous local anesthesia
44. Previous general anesthesia
45. Hepatitis
46. HIV/AIDS
47. Smoking
48. Bladder control
49. Heart murmur/do you premedicate with antibiotics?
50. Joint replacement/do you premedicate with antibiotics?
51. Atrial fibrillation

I hereby authorize the release of any medical information necessary to process claims and request payment of insurance benefits to either myself or the party who accepts assignment.

_____

Signature of Patient **Date**

PATIENT INFORMATION

Current Concern **Patient** _____

Describe your problem _____

_____

Which side hurts? Right Left Both

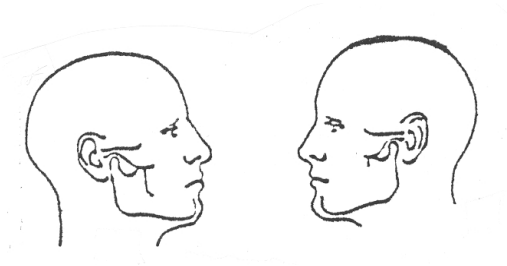
How long has it hurt? _____

Is the pain constant or intermittent? _____

Is the pain worse in the morning, afternoon or evening? _____

Does it hurt to move your jaw? _____ Does it hurt to chew? _____

On the figures below, please outline where you have pain:



Does your jaw make noise? (Circle one) Clicking Grinding Other _____

_____

Has your jaw ever locked open? _____ Has your jaw ever locked closed? _____

When? _____ How often? _____

If your jaw does not make noise or lock now, has it ever done so? _____

_____

Do you have:

Headaches	Neck aches	Ringing in the ears
Shoulder pain	Dizziness	Change in hearing
Ear pain	Other _____	

Do you grind or clench your teeth? _____

At night _____ During the day _____

PATIENT INFORMATION

Current Concern (continued) **Patient** _____

Do you have sore or sensitive teeth? _____

Do you have trouble getting to sleep? _____

Do you consider yourself to be under a lot of stress? _____

Have you ever had a nervous stomach, ulcers or skin disease? _____

Do you have or have you ever had arthritis? _____

Does your pain keep you from doing anything? If yes, what? _____

_____

Can you remember any injury to your jaw? If yes, describe. _____

_____

Do you take medication for the pain? If yes, please list. _____

_____

Do you take medication for relaxation? If yes, please list. _____

_____

Have you had any treatments for your problem? If yes, please circle:

Bite splint	Occlusal adjustment
Medication	Orthodontics
Physical therapy	Surgery
Counseling	Other _____

_____

Signature of Patient **Date**