The Art of Modern Dentistry

PATIENT'S HISTORY

This information is confidential and will not be released to anyone.

LEGAL NAME______________________ Nickname______________ SS#______________

ADDRESS______________________ CITY__________ STATE______ ZIP________

PHONE (H)__________ (W)__________ (C)__________ Email______________

DATE OF BIRTH ______ Age ____ ___MARRIED ___SINGLE ___MALE ___FEMALE

PERSON RESPONSIBLE FOR ACCOUNT______________________

SOCIAL SECURITY NUMBER______________ DRIVER'S LICENSE NUMBER______________

EMPLOYER______________ PHONE NUMBER______________

Who may we thank for referring you to our office? ______________________

When was your last visit to a dentist? ______________

Were full mouth X-rays taken then? Y N

Preferred filling color for back teeth: ___White ___Silver

Rate your smile: (dislike) 1- 2- 3- 4- 5 (love)

Would you like your teeth to be whiter? Y N

Chief dental complaint______________

Do your gums bleed or feel tender or irritated? Y N

Do you have halitosis (mouth odor)? Y N

Do you grind your teeth? Y N

Why did you leave your last dentist? ______________

Has your doctor said that you need to be premedicated before dental treatments? Y N

Do you use any tobacco products? Y N

WOMEN
Are you pregnant? Y N

If yes, when are you expecting? ______________

Are you taking birth control pills? Y N
(If yes, antibiotics may diminish the effect)

Do you have or have you had...

High blood pressure Y N

Heart trouble, Rheumatic fever or Heart Murmur Y N

Diabetes, Asthma, Tuberculosis Y N

Kidney or liver involvement or Hepatitis Y N

Venereal disease (Syphilis, Gonorrhea, Etc.) Y N

Immuno Suppressive Disorder (HIV or AIDS) Y N

Attention Deficit Disorder (ADD or ADHD) Y N

Sinus trouble Y N

Fainting spells or Seizures Y N

Have you taken Bisphosphonate therapy (Arebia, Zometa, Actonel, Boniva, Fosamax, Skelif, or Didronel)? (If yes, please circle) Y N

Allergic or sensitive to: Aspirin, Penicillin, Codeine, Local anesthetic, Erythromycin, Silver, Aluminum, Mercury, Tin, Copper, Zinc, Nickel, Chrome, Beryllium, Molybdenum, Latex, or any drugs (If yes, please circle) Y N

Subject to profuse bleeding? Y N

List of medications you are now taking: ______________
____

Other conditions? ______________

Acknowledgment of Kimberly Stokes D.D.S. Notice of Privacy Practices (HIPPA)

This signature below only acknowledge receipt of Kimberly Stokes D.D.S. Notice of Privacy Practices

______________ Print name of Patient/Representative
______________ Signature of Patient/Patient Representative
______________ Date

______ Check here if you decline to sign ______ Staff Initials

CONSENT

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aid deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also understand the use of anesthetic agents embodies certain risk. I understand that responsibility for payment for Dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered. I realize every attempt is made to correctly estimate co-payments; however, any unpaid balance after insurance pays is my responsibility. I also assign all insurance benefits to the Doctor. I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquires above have been answered to my satisfaction. I will not hold my Dentist responsible to any errors or omissions that I have made in the completion of this form. I will inform the Office Manager of any changes in my Health History or Insurance during subsequent appointments.

Patient Signature (Parent if minor) ______________________ Date______________