TRIPLE CITIES
FAMILY DENTAL, P.C.

ADULT
ACCOUNT INFORMATION

MR.____ MRS.____ MISS____ MS.____ DR.____ TODAY'S DATE_____

NAME_____ SEX____ BIRTHDATE_____

MARITAL STATUS_____ DRIVER'S LICENSE #_____

ADDRESS_____ HOME PHONE#_____

CITY_____ STATE_____ ZIP_____ CELL PHONE # _____

E-MAIL ADDRESS _____SOCIAL SECURITY #_____

EMPLOYER_____ OCCUPATION _____

EMPLOYER ADDRESS_____ WORK PHONE #_____

SPOUSE_____ SS#_____ BIRTHDATE _____

SPOUSE EMPLOYER_____ OCCUPATION_____

EMPLOYER ADDRESS_____ WORK PHONE #_____

PERSON RESPONSIBLE FOR DENTAL INVESTMENT_____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY _____

ADDRESS_____ PHONE #_____

WHOM MAY WE THANK FOR THIS REFERRAL? _____

DENTAL INSURANCE INFORMATION

PRIMARY

EMPLOYEE_____

INSURANCE CO. _____

ADDRESS _____

_____

GROUP #_____

SUBSCRIBER ID #_____

SECONDARY

EMPLOYEE _____

INSURANCE CO. _____

ADDRESS _____

_____

GROUP #_____

MEDICAL HISTORY

PLEASE CIRCLE THE APPROPRIATE RESPONSE. IF YOU DON'T KNOW THE CORRECT ANSWER, WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

1. Physician's Name .....
Address .....
2. Are you under a physician's care? ..... YES NO
Since when?_____ Why?_____
3. When was your last complete physical exam? _____
4. Are you taking any of the following medications:
   a. Antibiotics ..... YES NO
   b. Anticoagulants (blood thinners) ..... YES NO
   c. Medicine for high blood pressure ..... YES NO
   d. Cortisone (steroids) ..... YES NO
   e. Tranquilizers ..... YES NO
   f. Antihistamines ..... YES NO
   g. Aspirin ..... YES NO
   h. Insulin, tolbutamide (Orinase) or similar drug ..... YES NO
   i. Digitalis or drugs for heart trouble ..... YES NO
   j. Nitroglycerin ..... YES NO
   k. Oral contraceptive or other hormonal therapy ..... YES NO
   l. Fosamax, Actonel, Didrocal ..... YES NO
   m. Other (Please list all) ..... YES NO
5. Do you have or have you been treated for any of the following:
   a. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, arteriosclerosis) ..... YES NO
   b. Damaged heart valves or artificial heart valves ..... YES NO
   c. Stroke ..... YES NO
   d. High blood pressure ..... YES NO
   e. Heart murmur or mitral valve prolapse ..... YES NO
   f. Congenital heart lesions ..... YES NO
   g. Cardiac pacemaker ..... YES NO
   h. Fainting spells or seizures ..... YES NO
   i. Arthritis ..... YES NO
   j. Inflammatory rheumatism (painful swollen joints) ..... YES NO
   k. Hepatitis, jaundice or liver disease ..... YES NO
   l. Stomach ulcers or stomach problems ..... YES NO
   m. Kidney trouble ..... YES NO
   n. Tuberculosis ..... YES NO
   o. Do you have a persistent cough or cough up blood ..... YES NO
   p. Low blood pressure ..... YES NO
   q. Venereal disease ..... YES NO
   r. Epilepsy or seizure disorder ..... YES NO
   s. Psychiatric problems ..... YES NO
   t. Cancer ..... YES NO
   u. Rheumatic fever ..... YES NO
   v. Sinus trouble ..... YES NO
   w. Asthma or hay fever ..... YES NO
   x. Hives or skin rash ..... YES NO
   y. Diabetes ..... YES NO
   z. Spina Bifida ..... YES NO
6. Have you ever had a serious illness, condition or major surgery not listed? ..... YES NO
Explain: _____
7. Have you ever had surgery, chemo or radiation treatment for a tumor, growth or other condition? ..... YES NO
8. Do you have any blood disorders such as anemia or leukemia? ..... YES NO
9. Have you ever had a blood transfusion? ..... YES NO
10. Do you have an artificial joint/prosthesis? ..... YES NO

11. Have you been tested for HIV? ..... YES NO

11a. If so, what was the result? _____

12. Are you allergic to, or sensitive to, any of the following:
    a. Local anesthetics ..... YES NO
    b. Penicillin or other antibiotics ..... YES NO
    c. Sulfa drugs ..... YES NO
    d. Barbiturates, sedatives, or sleeping pills ..... YES NO
    e. Aspirin ..... YES NO
    f. Iodine ..... YES NO
    g. Codeine or other narcotics ..... YES NO
    h. Latex (rubber) ..... YES NO
    i. Any metals or jewelry ..... YES NO
    j. Other (please list) ..... YES NO
    k. Bananas, avocados, chestnuts or kiwis ..... YES NO

13. Do you smoke or chew tobacco? ..... YES NO
14. Do you habitually consume alcoholic beverages? ..... YES NO
15. Do you habitually use controlled substances? ..... YES NO

WOMEN

16. Are you pregnant or suspect you might be? ..... YES NO
17. Do you use any birth control medications? ..... YES NO
18. Are you nursing? ..... YES NO

DENTAL HISTORY

1. Purpose of this visit _____
   _____
2. How long since your last visit? _____
3. Have you lost any teeth or have any teeth been removed? ..... YES NO
4. Have they been replaced? ..... YES NO
5. Are you happy with the replacements? ..... YES NO
6. Would you like to know more about permanent replacements? ..... YES NO
7. Have you ever had any problems with previous dental treatment? ..... YES NO
   If yes, explain: _____
8. Do you clench or grind your teeth? ..... YES NO
9. Does your jaw click or pop? ..... YES NO
10. Do you have frequent headaches, neck or shoulder aches? ..... YES NO
11. Do your gums bleed or hurt? ..... YES NO
12. How often do you brush your teeth? .....
13. Do you use dental floss? ..... YES NO
14. Are you unhappy with the appearance of your teeth? ..... YES NO
15. Do you feel your breath is offensive at times? ..... YES NO
16. Have you ever had gum treatment or surgery? ..... YES NO
17. Have you ever had any orthodontic work? ..... YES NO
18. Do you have any questions or concerns? ..... YES NO
19. Is there anything you wish to discuss with the Doctor privately? ..... YES NO

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient Date