IMAGINE ADVANCED DENTAL ARTS

Patient Information

Date : _____

Name: _____ Male ☐ Female ☐
Last First MI Married ☐ Single ☐ Minor ☐

Address: _____
Street Apt# City State Zip

Place of Employment (or School): _____

Birthdate: ____/____/____ Whom may we thank for referring

Social Security No.: ___-___-____ you to our office? _____

Phone: ____/____/____ E-Mail: _____
Home Office Cell

Emergency Contact No.: _____/_____/_____
Name Phone Relation to patient

Family Information (Spouse or Parent/Guardian)

Name: _____ _____
Last First MI Relation to patient

Address: _____
Street Apt# City State Zip

Phone: ____/____
Home Office

Patient's Primary Dental Insurance Coverage

Insurance Plan Name_____ Group No.: _____

Subscriber _____ Subscriber Birthdate _____

Relation to Patient: Self ☐ Other _____ SS# ___-___-____
And/or
Employer: _____ Ins. ID #_____

Address: _____

Person Responsible For Account/Billing Address

Name: _____ _____
Last First MI Relation to patient

Address: _____
Street Apt# City State Zip

Phone: ____/____
Home Office

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. The information on this page and the medical history are correct to the best of my knowledge.

_____/_____
Signature of Responsible Party Date

HEALTH HISTORY

PATIENT NAME_____ DATE_____
(Please Print)

MEDICAL HISTORY

	Yes	No
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐

Please Explain _____

_____

_____

Are you under a PHYSICIAN'S CARE now?	☐	☐

FAMILY PHYSICIAN _____

PHONE_____

PHARMACY NAME/PHN# _____/_____

What MEDICATIONS are you currently taking? (Fill in or provide separate list):

_____

_____

_____

Do you SMOKE?	☐	☐
(For women) Are you PREGNANT?	☐	☐

How many months?_____

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING:

	Yes	No		Yes	No
High Blood Pressure	☐	☐	Arthritis	☐	☐
Heart Murmur	☐	☐	Herpes Virus	☐	☐
Rheumatic Fever	☐	☐	Cold Sores	☐	☐
Congenital Heart Lesions	☐	☐	Fever Blisters	☐	☐
Mitral Valve Prolapse	☐	☐	AIDS/ARC/HIV Pos.	☐	☐
Heart Pacemaker	☐	☐	Hepatitis A (Infectious)	☐	☐
Heart Surgery	☐	☐	Hepatitis B (Serum)	☐	☐
Fen-Phen/Redux	☐	☐	Hepatitis C (Serum)	☐	☐
Artificial Joints (Hip, Knee)	☐	☐	Persistent Cough	☐	☐
Stroke	☐	☐	Liver Disease	☐	☐
Kidney Trouble	☐	☐	Glaucoma	☐	☐
Recent Weight Loss	☐	☐	Psychiatric Treatment	☐	☐
Blood Transfusion	☐	☐	Cancer	☐	☐
Hemophilia/Bleeding Problems	☐	☐	Radiation Treatment	☐	☐
Chest Pain	☐	☐	Chemotherapy	☐	☐
Shortness of Breath	☐	☐	Venereal Disease	☐	☐
Swelling-Feet/Ankles/Hands	☐	☐	Bruise Easily	☐	☐
Ulcers	☐	☐	Emphysema	☐	☐
Sinus Trouble	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Epilepsy/ Seizures	☐	☐
Diabetes	☐	☐	Drug/Alchohol Addiction	☐	☐
Thyroid Disease	☐	☐	Other _____		
Hypoglycemia	☐	☐	_____		

Imagine Advanced Dental Arts

DENTAL HISTORY

HOW LONG SINCE you have seen a Dentist? _____

Name of PREVIOUS DENTIST _____

DATE of last COMPLETE dental exam? _____

DATE of last FULL MOUTH X-RAYS _____

DO you have a SPECIFIC DENTAL PROBLEM? (Explain)_____

_____

HAVE you ever had a BAD EXPERIENCE in a Dental office? (Describe)_____

_____

	Yes	*No*
Have you had any PERIODONTAL (gum) treatments?	☐	☐
Do your gums BLEED when you brush your teeth	☐	☐
Are they RED, SWOLLEN or TENDER?	☐	☐
Are your teeth SENSITIVE to: HOT COLD SWEETS PRESSURE (Circle)	☐	☐
Have you noticed a difference in the way your teeth FIT when biting?	☐	☐
Does any tooth HURT when you bite?	☐	☐
Do you have persistent BAD BREATH?	☐	☐
Are you unhappy with the APPEARANCE of your teeth?	☐	☐
Do your feel SELF-CONSCIOUS when you smile?	☐	☐
Would you be interested in WHITENING your teeth?	☐	☐
Would improving your SMILE make you feel more confident?	☐	☐
Would you be interested in STRAIGHTENING your teeth?	☐	☐
Have you ever had ORTHODONTICS (BRACES)?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you ever experience CLICKING/ POPPING in your JAW?	☐	☐

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin	☐	Local Anesthetic	☐	Erythromycin	☐
Nitrous Oxide	☐	Codeine	☐	Penicillin	☐

Are you aware of being allergic to other medications or substances (Latex, Wool, Metals, Chemicals)?_____

_____

Is there any other Medical or Dental information that you feel we should know about? (Specify) _____

I hereby authorize the dental office to administer such medication and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

PATIENT SIGNATURE _____

REVIEWED BY (DR.) _____

REMARKS: _____

_____