PATIENT INFORMATION FORM

Today's Date:_____

Name:_____

Address:_____

City:_____ State:___ Zip:_____

Home Phone:_____

Cell:_____

E-mail:_____

Preferred method of contact: (please check all that apply)

E-mail____ Home phone____ Cell phone____

Birth date:_____ Age:_____

Married___ Single___ Divorced___ Widowed___

INSURANCE

Primary Insurance Company:_____

Subscriber Name:_____

Subscriber's Birthdate:_____

Subscriber's ID/SSN:_____

Secondary Insurance Company:_____

Subscriber Name:_____

Subscriber's Birthdate:_____

Subscriber's ID/SSN:_____

ACCOUNT INFORMATION

Person responsible for account: _____

PATIENT

Name: _____

Occupation: _____

Employer:_____

Business Phone:_____

SPOUSE/SIGNIFICANT OTHER

Name:_____

GETTING TO KNOW YOU

Is another member of your family, or relative a patient at our office?_____

Referred to us by: _____

Convenient appointment day/time:_____

Emergency Contact

Name:_____

Relationship:_____

Phone:_____

DENTAL HISTORY

	YES	NO
Are you afraid of receiving dental care?	☐	☐
Are you happy with the appearance of your teeth?	☐	☐
Do you have any TMJ/Jaw problems?	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you have earaches or neck pains?	☐	☐
Are your teeth sensitive to hot/cold/sweet?	☐	☐
Do your gums bleed?	☐	☐
Have you ever had gum surgery?	☐	☐
Have you had deep cleaning/scaling/root planning?	☐	☐
Does food or floss catch between your teeth?	☐	☐
Have you ever had orthodontic treatment?	☐	☐
Do you have a dental problem now?	☐	☐

	YES	NO
Is your mouth dry?	☐	☐
Are you satisfied with previous dental care?	☐	☐
Have you had problems after dental treatment?	☐	☐

Previous Dentist's name:_____

When was your last cleaning?_____

When were your last x-rays?_____

Please list any tobacco products that you have used

_____

Do you have questions/concerns to discuss?_____

_____

Is there any other dental information we should know about?_____

If yes, please explain_____

What is the reason for your visit today?_____

MEDICAL HISTORY

The following information is essential for the safe and effective diagnosis and treatment of each patient.
Please check if you now have or ever had:

	Yes	No		Yes	No
Autoimmune disease (Lupus, Sjorgens, other)	☐	☐	Herpes	☐	☐
Rheumatoid arthritis	☐	☐	Diabetes (Type 1, Type 2)	☐	☐
Congenital heart disease	☐	☐	Thyroid disease	☐	☐
Heart Attack	☐	☐	Kidney disease/Dialysis	☐	☐
Heart murmur	☐	☐	Ulcers	☐	☐
Rheumatic fever	☐	☐	Epilepsy/Seizures	☐	☐
Mitral valve prolapsed	☐	☐	Drug/Alcohol Treatment/Dependency	☐	☐
Irregular heart beat	☐	☐	Steroid treatment	☐	☐
Angina/Chest pain	☐	☐	Artificial Joints/Pins, Plates	☐	☐
Heart surgery	☐	☐	If yes, which joint, date:_____		
Heart pace maker	☐	☐	Sinus problems	☐	☐
Artificial heart valve	☐	☐	Mental health disorders	☐	☐
High blood pressure	☐	☐	Osteoporosis	☐	☐
Low blood pressure	☐	☐	Glaucoma	☐	☐
Stroke	☐	☐	Eating disorder	☐	☐
Anemia	☐	☐	Gastrointestinal disease/Chron's Disease	☐	☐
Hemophilia/Bleeding/Bruise easily	☐	☐	Acid reflux/persistent heartburn	☐	☐
AIDS/HIV positive//Immune Supression	☐	☐	Tuberculosis	☐	☐
Blood transfusion If yes, date:_____	☐	☐	Asthma	☐	☐
Hepatitis A (infectious), B, C	☐	☐	Bronchitis	☐	☐
Liver disease	☐	☐	Lung disease/Emphysema	☐	☐
Cancer/Chemo/Radiation	☐	☐	Allergies to medications	☐	☐
If yes, type, dates:_____			If yes,please list:_____		

_____ _____

Do you have any disease, condition, or problem not listed above that you think I should know about?_____

_____

Are you taking or have you ever used in the past any Bisphosphonate drug such as Fosamax, Zometa, Didronel, Reclast, Aredia, Atelvia, or Skelid for Osteoporosis, Paget's Disease or Multiple Myloma?

YES ☐ **NO** ☐ If yes, please list:_____

_____

Dates:_____

WOMEN ONLY	**YES**	**NO**
Are you Pregnant?	☐	☐
If yes, number of weeks?_____		
Nursing?	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐

List current medications (include all prescription, vitamins, over the counter or natural supplements):

_____

_____

To the best of my knowledge, the above questions have been accurately answered. If any changes in my health status or medication changes, I will inform the office. I understand, hereby authorize Dr. Bauer to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient needs. I also authorize Dr. Bauer to perform routine treatment that may be indicated and further authorize and consent that the doctor choose and employ such assistance as he deems fit. I understand the use of anesthetic agents embodies a certain risk. I understand that I may ask any and all questions I have at any time. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine. DUE AND PAYABLE AT THE TIME OF SERVICE UNLESS PRIOR FINANCIAL ARRANGEMENTS ARE MADE. I also understand a finance charge of 21% APR may be accessed on my outstanding balance over thirty days.

_____ _____ _____

Date Print patient Name Patient Signature/ Parent or Guardian Signature