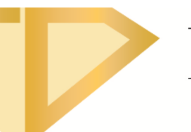
TRACEY  DENTAL

PATIENT INFORMATION	CONFIDENTIAL
NAME ____________	BIRTHDATE ____________
ADDRESS ____________	HOME PHONE ____________
CITY ____________ STATE ______ ZIP ______	
PATIENT OR PARENT'S EMPLOYER ____________	CIRCLE APPROPRIATE SELECTION:
BUSINESS ADDRESS ____________	MINOR SINGLE MARRIED
CITY _____+__________ STATE ______ ZIP ______	WORK PHONE ____________
IF PT IS A STUDENT, NAME OF SCHOOL ____________	CELL PHONE____________
CITY ____________ STATE ______	EMAIL ____________
WHOM MAY WE THANK FOR REFERRING YOU? ____________	

RESPONSIBLE PARTY	
NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ____________ ____________	RELATIONSHIP TO PATIENT ______
ADDRESS ____________	HOME PHONE ____________
	WORK PHONE ____________
CITY ____________ STATE ______ ZIP ______	CELL PHONE ____________
	BIRTHDATE ____________
EMPLOYER ____________	SS NUMBER ____________
ADDRESS ____________	
CITY ____________ STATE ______ ZIP ______	

INSURANCE INFORMATION	
NAME OF INSURED ____________	RELATIONSHIP TO PATIENT ______
INSURANCE COMPANY ____________	BIRTHDATE ____________
ADDRESS ____________	SS NUMBER ____________
CITY ____________ STATE ______ ZIP ______	GROUP NUMBER ____________
	INSURANCE PHONE ____________

PATIENT NAME ____

ADDITIONAL INSURANCE

NAME OF INSURED _______________________________________

INURANCE COMPANY ____________________________________

ADDRESS ____

CITY ___________________ STATE ______________ ZIP _________

RELATIONSHIP TO PATIENT _________

BIRTHDATE ______________________

SS NUMBER _____________________

GROUP NUMBER __________________

INSURANCE PHONE _______________

PATIENT MEDICAL HISTORY

PHYSICIAN NAME ____

- ARE YOU UNDER THE CARE OF A PHYSICIAN? YES NO
- HAVE YOU BEEN HOSPITALIZED IN THE LAST FIVE YEARS? YES NO
- ARE YOU TAKING MEDICATIONS? INCLUDING OVER THE COUNTER AND PRESCRIPTION. YES NO
- DO YOU USE TOBACCO? YES NO
- DO YOU USE ALCOHOL? YES NO
- DO YOU USE COCAINE OR OTHER DRUGS? YES NO
- DO YOU HAVE ANY ALLERGIES? YES NO
  ____
  ____
- PLEASE LIST MEDICATIONS YOU ARE CURRENTLY TAKING:
  ____
  ____
- HAVE YOU EVER HAD A REACTION TO ANESTHETIC? YES NO

EXPLAIN ABOVE:
____

PHYSICIAN PHONE ________________

DATE OF LAST EXAM _______________

WOMEN ONLY:

- ARE YOU PREGNANT ________
- ARE YOU NURSING _________
- ARE YOU TAKING BIRTH CONTROL PILLS ____________

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS ABOUT YOURSELF: (*MARK ALL ANSWERS WITH A YES OR NO)*

	YES	NO		YES	NO		YES	NO
HIGH BLOOD PRESSURE	___	___	FREQUENTLY TIRED	___	___	KIDNEY DISEASE	___	___
HEART ATTACK	___	___	ANEMIA	___	___	AIDS/HIV INFECTION	___	___
RHEUMATIC FEVER	___	___	EMPHYSEMA	___	___	STD'S	___	___
SWOLLEN ANKLES	___	___	CANCER	___	__	THYROID PROBLEMS	___	___
FAINING/SEIZURES	___	___	ARTHRITIS	___	__	HEPATITIS A, B OR C	___	___
ASTHMA	___	___	JOINT REPLACEMENT	___	__	ULCERS	___	___
LOW BLOOD PRESSURE	___	___	CHEST PAINS	___	__	RESPIRATORY PROBLEMS	___	___
EPILEPSY/CONVULSIONS	___	___	SHORT OF BREATH	___	___	OTHER ______________		
LEUKEMIA	___	___	STROKE	___	___	______________		
DIABETES	___	___	HAY FEVER/ALLERGIES	___	__	______________		
HEART DISEASE	___	___	TUBERCULOSIS	___	___	______________		
CARDIAC PACE MAKER	___	___	RADIATION THERAPY	___	___	______________		
HEART MURMER	___	___	GLAUCOMA	___	___	______________		
ANGINA	___	___	LIVER DISEASE	___	___			

PATIENT DENTAL HISTORY

1. **DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?**
2. **ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS OR FOODS?**
3. **ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS OR FOODS?**
4. **DO YOU FEEL PAIN IN ANY OF YOUR TEETH?**
5. **HAVE YOU EVER SUFFERED TRAUMA TO YOUR FACE MOUTH OR JAW?**
6. **DOES YOUR JAW EVER CLICK, POP, CRACKLE OR ACHE?**
7. **DO YOU HAVE PAIN IN YOUR JAW JOINT, EAR OR SIDE OF THE FACE?**
8. **DO YOU HAVE DIFFICULTY OPENING OR CLOSING YOUR MOUTH?**
9. **DO YOU CLENCH OR GRIND YOUR TEETH?**
10. **HAVE YOU HAD PROBLEMS WITH PREVIOUS DENTAL WORK?**

GOALS FOR YOUR MOUTH, TEETH AND SMILE:________________________
____
____

WHAT WOULD YOU CHANGE ABOUT YOUR SMILE, IF ANYTHING AT ALL?
____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

____
PATIENT SIGNATURE

____
PRINT NAME

____
DATE

____
DENTIST SIGNATURE

____
DATE

____
WITNESS SIGNATURE

____
DATE