Dental Care
HILLSBOROUGH

## Personal Information Form

Patients Name:_____ How do you prefer to be addresses?:_____

Sex (Circle One): Male Female Marital Status (Circle One): Single Married Widow Separated Divorced

Birth Date:_____/_____/_____ Age:_____ SS#:_____ Driver's License #:_____

Mailing Address:_____ City: _____ State:_____ Zip:_____

E-mail:_____ Home Phone: (_____)_____

Work Phone: (_____)_____ Fax: (_____)_____ Cell: (_____)_____

Occupation:_____Employer:_____

Employer Address:_____City:_____State:_____Zip:_____

If Student, Name of School/College: PT FT _____ City:_____ State:_____ Zip:_____

Who can we thank you for referring you to our office: _____

**If the person responsible for this payment is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section entitled "Insurance Information."**

Name of Responsible Party:_____ Relationship to Patient:_____

Mailing Address:_____ City: _____ State:_____ Zip:_____

E-mail:_____ Home Phone: (_____)_____

Work Phone: (_____)_____ Fax: (_____)_____ Cell: (_____)_____

Occupation:_____Employer:_____

Employer Address:_____City:_____State:_____Zip:_____

### INSURANCE INFORMATION

Policy Holders Name:_____ Relationship to Patient:_____

Birth Date:_____/_____/_____ SS#:_____ Employer:_____

Employer Address:_____City:_____State:_____Zip:_____

Insurance Co:_____ Insurance Address:_____

Group#:_____ ID#:_____

### SECONDARY INSURANCE INFORMATION

Policy Holders Name:_____ Relationship to Patient:_____

Birth Date:_____/_____/_____ SS#:_____ Employer:_____

Employer Address:_____City:_____State:_____Zip:_____

Insurance Co:_____ Insurance Address:_____

Group#:_____ ID#:_____

I certify that all the information (including medical, personal, and insurance records) is true and complete. I give my full permission to Dental Care Bridgewater to check and verify my credit and/or employment history. I further understand that Dental Care of Bridgewater will assist me in filing my claims, but the insurance coverage I have for dental services can vary and will depend on my insurance plane.

I understand that I am responsible for all fees and services. Since our doctors often proved continuing education to other doctors, I give mu permission to use my photos for educational purposes.

If the patient is a minor, as the responsible party I give permission, in my absence, to provide examinations, dental clearings and necessary x-rays as part of routine care for this patient.

We require 48 hours advance notice if you are unable to keep your appointment. Failure to do so could result in a charge. Finance charges will be assessed on any account that is 60 days or more past due at the rate of 1.5% per month. Thank you for your cooperation.

Signature of Patient or Guardian: _____ Date:_____

# Medical and Dental Health History Form

Medical Doctor's Name:_____ Doctor's Phone #:_____ Date of last complete physical: _____

Doctor's Address: _____ City:_____ State:_____ Zip:_____

Are you taking any medication, vitamins or supplements? Yes_____ No_____

If yes, please list:_____

For what purpose?_____

Are you pregnant? Yes_____ No_____ If yes, how many months: _____

Rate your medical health: Excellent Good Fair Poor (Circle one)

Are you allergic to Penicillin, Codeine, Local injected Anesthetic, Latex, Other (Circle all that apply)

Do you have a heart murmur, heart condition, diabetes, joint replacements, implants? (Circle all that apply)

Have you been told that because of this that you need to take antibiotics prior to dental cleanings or other treatment? Yes___ No___

(explain)_____

Do you have or have you ever had any of the following

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Arthritis | _____ | _____ | Persistent cough | _____ | _____ |
| Radiation treatments | _____ | _____ | Aids, HIV positive | _____ | _____ |
| Malignancies | _____ | _____ | Prolonged bleeding | _____ | _____ |
| Heart murmur/MVP/ Rheumatism | _____ | _____ | Headache, neck, jaw pain, or TMJ Dys. | _____ | _____ |
| Excessive urination | _____ | _____ | Psychiatric care or nervous problems | _____ | _____ |
| Anemia | _____ | _____ | High or low blood pressure (circle one) | _____ | _____ |
| Ulcers | _____ | _____ | Epilepsy | _____ | _____ |
| Sinus trouble | _____ | _____ | Jaundice/Hepatitis | _____ | _____ |
| Herpes | _____ | _____ | Narrow Angle Glaucoma | _____ | _____ |
| Asthma or hay fever | _____ | _____ | Sensitivity to epinephrine | _____ | _____ |

**How would you rate your dental health? Excellent Good Fair Poor (Circle one)**

**If not excellent, what is the barrier? Fear, time, other** _____

**How would you rate the appearance of your smile? Excellent Good Fair Poor (Circle one)**

**What would you like to improve? Color of teeth, shape, dark old fillings, crooked teeth, other_____(Circle all that apply)**

**Do you ever get head, neck, or facial pain? Yes_____ No_____ How often?_____**

**Stress headaches Migraines TM Joint pains Earaches Sensitive Teeth Clicking in Jaw Joint**

(Circle all that apply)

Please describe any current treatment, impending operation, or any other medical or dental condition that you have.

_____

_____

## Family Member Information

| Please list the names of your spouse and children. | Is person a patient? | | Sex | | Age | Date of birth |
|---|---|---|---|---|---|---|
| | Yes | No | M | F | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

| Please list the names of your spouse and children. | Is person a patient? | | Sex | | Age | Date of birth |
|---|---|---|---|---|---|---|
| | Yes | No | M | F | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Please Complete Both Sides**

Dental Care
HILLSBOROUGH

# *DENTAL HEALTH HISTORY*

**PATIENT'S NAME:** _____ **DATE:** _____

1. Is keeping your teeth important to you? [Y] [N] If yes, why? _____
2. On a scale of 1-10, 10 being the best, where would you rate your smile?
3. On a scale of 1-10, 10 being the best, where you rate your oral health?
4. Is the brightness of your teeth important to you? [Y] [N]
5. Have you experienced any of the following problems:

| | |
|---|---|
| Bleeding gums [Y] [N], | Sensitivity to Hot & Cold [Y] [N] |
| Bad Breath or sour taste in mouth [Y] [N] | Snoring [Y] [N] |
| Burning sensations in mouth [Y] [N] | Food catching between teeth [Y] [N] |
| Soreness in jaw [Y] [N], | Grinding of Teeth [Y] [N] |
| Is it hard for you to open wide? [Y] [N] | Pain/soreness around ears, eyes, face [Y] [N] |
| Clicking or popping in jaw [Y] [N] | Stiff neck muscles [Y] [N] |
| Dry Mouth [Y] [N] | Headaches/Migraines [Y] [N] |

6. Does having dental treatment make you afraid or nervous? [Y] [N] If yes, what specific things bother you?

_____

7. If you could change anything about your smile which of the following would you want?

| | | |
|---|---|---|
| Whiter [Y] [N] | Straighter [Y] [N] | Close space or spaces [Y] [N] |
| Replace missing teeth [Y] [N] | Less Gum showing [Y] [N] | Replace old crowns [Y] [N] |
| Excess showing of Teeth [Y] [N] | Replace old plastic filling(s) [Y] [N] | Remove Stains/Spots on teeth [Y] [N] |
| Reshape/resize my teeth [Y] [N] | Replace chipped teeth [Y] [N] | Remove silver fillings [Y] [N] |

8. Fill in this question for us please: Where do you see yourself and your overall oral health and/or your smile in the next 5 to 10 years?

**Please circle the following which are important to you when making your dental health decision.**

| | | |
|---|---|---|
| Convenience | Appearance | Relationship with Dental Team |
| Finances | Time | Quality of care |
| Dental Insurance | Health | Detailed treatment explanations |