PATIENT INFORMATION

Welcome and thank you for choosing Serene Dental Care! If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name (*Last, First Middle*) _____ Date _____

☐ Male ☐ Female SSN _____-_____-_____ DOB _____/_____/_____

Address _____ Home Phone (_____) _____ - _____

City _____ State _____ Zip Code _____

Employer _____ Occupation _____

Address _____ Work Phone (_____) _____ - _____

City _____ State _____ Zip Code _____

Person to contact in case of emergency: Name *(Last, First)* _____

Relationship to Patient _____ Phone (_____) _____ - _____

Whom may we thank for referring you ? _____

INSURANCE INFORMATION

Subscriber (Last, First) _____ Relationship to Patient _____

Employer _____ DOB _____/_____/_____ SSN _____-_____-_____

Insurance Co. _____

Group # _____ Policy # _____

I authorize the release of information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I understand that I am financially responsible for all charges whether or not paid by the insurance company. I also hereby assign payment of insurance benefits to Serene Dental Care, otherwise payable to me, for services rendered.

_____ _____/_____/_____

Signature of patient (or parent/guardian if patient is a minor) Date

DENTAL HISTORY

Reason for today's visit _____

Former dentist _____ City/State _____

Date of last dental visit _____ Date of last dental x-rays _____

Please mark "Yes" or "No" to indicate if you have had any of the following.

Y N		Y N		Y N	
☐	☐ Bad breath	☐	☐ Foreign objects	☐	☐ Periodontal treatment
☐	☐ Bleeding gums	☐	☐ Grinding teeth	☐	☐ Sensitivity to cold
☐	☐ Blisters on lips/mouth	☐	☐ Gums swollen/tender	☐	☐ Sensitivity to heat
☐	☐ Burning sensation on tongue	☐	☐ Jaw pain/tiredness	☐	☐ Sensitivity to sweet
☐	☐ Chew on one side of mouth	☐	☐ Lip/cheek biting	☐	☐ Sensitivity when biting
☐	☐ Cigarette/pipe/cigar smoking	☐	☐ Loose teeth/broken fillings	☐	☐ Sores/growths in mouth
☐	☐ Clicking/popping jaw	☐	☐ Mouth breathing		
☐	☐ Dry mouth	☐	☐ Mouth pain when brushing	How often do you floss? _____	
☐	☐ Fingernail biting	☐	☐ Orthodontic treatment		
☐	☐ Food collection between teeth	☐	☐ Pain around ear	How often do you brush? _____	

HEALTH HISTORY

Medical doctor's name _____

Please mark "Yes" or "No" to indicate if you have had any of the following:

Y	N		Y	N		Y	N	
☐	☐	AIDS	☐	☐	Epilepsy	☐	☐	Radiation treatment
☐	☐	Anemia	☐	☐	Fainting/dizziness	☐	☐	Respiratory disease
☐	☐	Arthritis, Rheumatism	☐	☐	Glaucoma	☐	☐	Rheumatic fever
☐	☐	Artificial heart valves	☐	☐	Headaches	☐	☐	Scarlet fever
☐	☐	Artificial joints	☐	☐	Heart murmur	☐	☐	Shortness of breath
☐	☐	Asthma	☐	☐	Hepatitis	☐	☐	Sinus trouble
☐	☐	Back problems			Type _____	☐	☐	Skin rash
☐	☐	Bleeding abnormally	☐	☐	Herpes	☐	☐	Stroke
☐	☐	Blood disease	☐	☐	High blood pressure	☐	☐	Swelling of feet/ankles
☐	☐	Cancer	☐	☐	Jaundice	☐	☐	Swollen neck glands
☐	☐	Chemotherapy	☐	☐	Kidney disease	☐	☐	Thyroid problems
☐	☐	Circulatory problems	☐	☐	Liver disease	☐	☐	Tonsillitis
☐	☐	Congenital heart lesions	☐	☐	Low blood pressure	☐	☐	Tuberculosis
☐	☐	Contact lens wearer	☐	☐	Mitral valve prolapse	☐	☐	Tumor/growth on neck/head
☐	☐	Cortisone treatments	☐	☐	Nervous problems			
☐	☐	Cough, persistent or bloody	☐	☐	Pacemaker	☐	☐	Ulcer
☐	☐	Diabetes	☐	☐	Phen-fen	☐	☐	Venereal disease
☐	☐	Emphysema	☐	☐	Psychiatric care	☐	☐	Weight loss, unexplained

Women: Are you pregnant? ☐ Yes ☐ No Due Date _____ Are you nursing? ☐ Yes ☐ No

List medications you are currently taking:

_____

_____

_____

ALLERGIES:

☐ Bleach products ☐ Penicillin
☐ Codeine ☐ Sulfa
☐ Latex ☐ Other _____
☐ Local anesthetic _____

I have read my MEDICAL HISTORY and confirm that it adequately reflects past and present conditions.

Date	Exceptions		Patient's signature	Reviewed by
_____	_____	☐ NONE	_____	_____
_____	_____	☐ NONE	_____	_____
_____	_____	☐ NONE	_____	_____
_____	_____	☐ NONE	_____	_____
_____	_____	☐ NONE	_____	_____
_____	_____	☐ NONE	_____	_____
_____	_____	☐ NONE	_____	_____
_____	_____	☐ NONE	_____	_____