Patient Name____

Dental History

Pain in mouth
Sensitivity (hot, cold, sweets, pressure)
Discomfort when chewing
Headaches, ear aches, neck pain
Jaw joint pain
Teeth or fillings breaking
Repair chipped teeth
Grinding or clenching teeth
Bleeding, swollen or irritated gums
Loose, chipped or shifting your mouth
Bad breath or bad taste in your mouth

*What is the reason for visit today?

____

*When was your last dental visit?

____

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

Braces
Periodontal (gum) treatments
CPAP machine
Dentures
Partial Dentures

*Are you interested in :
Close spaces
Replace old crowns that don't match other teeth
Whitening
Straighten
Replace silver fillings with tooth colored fillings
Replace missing teeth
Sedation dentistry: Nitrous IV
Botox/Filler

*Name of previous dentist

____

Medical History

AIDS/HIV positive
Anemia
Arthritis
Artificial Joints
Asthma
Blood Disease
Blood Thinner
Cancer
Chemotherapy Dates
Diabetes Type 1 Type 2
Dizziness
Epilepsy
Excessive Bleeding
Fainting
Glaucoma
Growths
Hay Fever
Head Injuries
Heart Disease
Heart Murmur/Mitro Valve Prolapse
Hepatitis A B C
High Blood Pressure
Jaundice
Kidney Disease
Liver Disease
Mental Disorders
Nervousness/Depression
Pacemaker
Pregnant (currently) due date__________________
Radiation Treatment
Respiratory Problems
Rheumatism
Sinus Problems
Stent
Stomach Problems
Stroke
Thyroid Disease
Tobacco User (currently)
Tuberculosis
Tumors
Ulcers
Venereal Disease
Other__________________

____

____

*Medication list:

____

____

____

____

____

____

____

____

____

*Do you have any allergies?
Yes No
Penicillin
clindamycin
Codeine
Sulfa Drugs
Latex
Costume Jewelry
IF other list:

____

____

____

*Are you taking any osteoporosis medications?
Yes No
If yes list medications:

____

*Past surgical history:

____

____

____

____

*Family Doctor:

____

*Family Doctor Phone Number:

____

Patient/Parent Signature______________________________________ Date______________________

Doctor Signature____ Date______________________

PARK HILLS DENTISTRY
FAMILY & COSMETIC

Patient Information

Patient Name: ____ Today's Date: __________

Sex: __M __F Birth Date:__________________ Age:___________ SSN:_______________________

Occupation:______________________ check one : ____ Single ____ Married ____Widowed

Home Address:____________________________ City:________________ State: ______ Zip: __________

Email:____

Home Phone #:_______________________________ Cell:__________________________________

Your Employer:____

If patient is underage: Mother's DOB:__________________ Father's DOB:_______________________

Emergency Information

Name:____________________________________ Phone#:___________________________________

Pharmacy Information

Pharmacy Name:__________________________________Phone#:____________________________

How did you hear about us? _ Mail __ Handed Flyer __Facebook __Instagram__ Google __ Yelp __
Personal Referral: name of referring you to us:______________________________________

Person Responsible for Account:_________________________ SSN:__________________________

Email Address:_______________________________________ Home #:______________________

Cell:_____________________________ Employer:______________________________________

Dental Insurance Information (*Primary Carrier*) if you have other dental insurance coverage please fill out second coverage insurance.

Insured's Name: _________________________ SSN:__________________DOB:___________ Insured's Employer:________________________ Insured's Company:______________________

Insurance Company Address: ____

Phone #:_____________ Group #:___________ Local #:______________________________

Insured's Name: _________________________ SSN:__________________DOB:___________

Insured's Employer:________________________ Insured's Company:______________________

Insurance Company Address: ____

Phone #:_____________ Group #:___________ Local #:______________________________