PRILL DENTAL

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PATIENT INFORMATION

CONFIDENTIAL

PATIENT # ____________

DATE ____________

(PLEASE PRINT)

NAME ____________ (FIRST ____ MI ____ LAST ____) BIRTHDATE ____________ HOME PHONE ____________

ADDRESS ____________ CITY ____________ STATE/ PROV. ______ ZIP/ P.C. ______

E-MAIL ____________ CELL PHONE ____________

S.S.N. ____________

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER ____________ WORK PHONE ____________

BUSINESS ADDRESS ____________ CITY ____________ STATE/ PROV. ______ ZIP/ P.C. ______

SPOUSE OR PARENT/GUARDIAN'S EMPLOYER ______ EMPLOYER ____________ WORK PHONE ____________

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE ____________ CITY ______ STATE/ PROV. ______

WHOM MAY WE THANK FOR REFERRING YOU? ____________

PERSON TO CONTACT IN CASE OF EMERGENCY ____________ PHONE ____________

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ____________ RELATIONSHIP TO PATIENT ____________

INSURANCE INFORMATION

NAME OF INSURED ____________ RELATIONSHIP TO PATIENT ____________

BIRTHDATE ____________ SS #/SIN ____________ DATE EMPLOYED ____________

NAME OF EMPLOYER ____________ WORK PHONE ____________

BUSINESS ADDRESS ____________ CITY ____________ STATE/ PROV. ______ ZIP/ P.C. ______

INSURANCE COMPANY ____________ GROUP # ____________ UNION OR LOCAL # ____________

INS. CO. ADDRESS ____________ CITY ____________ STATE/ PROV. ______ ZIP/ P.C. ______

INSURANCE ID # ____________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED ____________ RELATIONSHIP TO PATIENT ____________

BIRTHDATE ____________ SS #/SIN ____________ DATE EMPLOYED ____________

NAME OF EMPLOYER ____________ WORK PHONE ____________

ADDRESS OF EMPLOYER ____________ CITY ____________ STATE/ PROV. ______ ZIP/ P.C. ______

INSURANCE COMPANY ____________ GROUP # ____________ UNION OR LOCAL # ____________

INS. CO. ADDRESS ____________ CITY ____________ STATE/ PROV. ______ ZIP/ P.C. ______

HOW MUCH IS YOUR DEDUCTIBLE? ______ HOW MUCH HAVE YOU USED? ______ MAX. ANNUAL BENEFIT? ______

X ____________

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

SIGNATURE

PATIENT NAME

PATIENT NAME ______	TODAY'S DATE ______
HOME ADDRESS ______	DATE OF BIRTH ______
______	HOME PHONE ______
E-MAIL ______	CELL PHONE ______
BUSINESS ADDRESS ______	BUSINESS PHONE ______
______	SS #/SIN ______

PATIENT MEDICAL HISTORY

PHYSICIAN ______ OFFICE PHONE ______ DATE OF LAST EXAM ______

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐

IF YES, WHAT MEDICATION(S) ARE YOU TAKING? ______

______

	YES	NO
4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	☐	☐
5. DO YOU USE TOBACCO?	☐	☐
6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	☐	☐
7. ARE YOU WEARING CONTACT LENSES?	☐	☐

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	LOCAL ANESTHETICS (E.G. NOVOCAINE)	☐	☐	BARBITURATES	☐	☐	ASPIRIN
☐	☐	PENICILLIN OR OTHER ANTIBIOTICS	☐	☐	SEDATIVES	☐	☐	OTHER ______
☐	☐	SULFA DRUGS	☐	☐	IODINE			______

	YES	NO
9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)?	☐	☐
10. WOMEN ONLY:		
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	HEART DISEASE	☐	☐	CHEST PAINS
☐	☐	HEART ATTACK	☐	☐	CARDIAC PACEMAKER	☐	☐	EASILY WINDED
☐	☐	RHEUMATIC FEVER	☐	☐	HEART MURMUR	☐	☐	STROKE
☐	☐	SWOLLEN ANKLES	☐	☐	ANGINA	☐	☐	HAY FEVER / ALLERGIES
☐	☐	FAINTING / SEIZURES	☐	☐	FREQUENTLY TIRED	☐	☐	TUBERCULOSIS
☐	☐	ASTHMA	☐	☐	ANEMIA	☐	☐	RADIATION THERAPY
☐	☐	LOW BLOOD PRESSURE	☐	☐	EMPHYSEMA	☐	☐	GLAUCOMA
☐	☐	EPILEPSY / CONVULSIONS	☐	☐	CANCER	☐	☐	RECENT WEIGHT LOSS
☐	☐	LEUKEMIA	☐	☐	ARTHRITIS	☐	☐	LIVER DISEASE
☐	☐	DIABETES	☐	☐	JOINT REPLACEMENT OR IMPLANT	☐	☐	HEART TROUBLE
☐	☐	KIDNEY DISEASES	☐	☐	HEPATITIS / JAUNDICE	☐	☐	RESPIRATORY PROBLEMS
☐	☐	AIDS OR HIV INFECTION	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐	OTHER ______
☐	☐	THYROID PROBLEM	☐	☐	STOMACH TROUBLES / ULCERS			______

COMMENTS

______

______

______

______

SIGNATURE OF DENTIST ______ DATE ______

PATIENT DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	☐	☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐	☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
A) CLICKING?	☐	☐
B) PAIN (JOINT, EAR, SIDE OF FACE)?	☐	☐
C) DIFFICULTY IN OPENING OR CLOSING?	☐	☐
D) DIFFICULTY IN CHEWING?	☐	☐
8. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
12. HAVE YOU HAD ANY ORTHODONTIC WORK?	☐	☐
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	☐	☐
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	☐	☐

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X ______ PATIENT, PARENT OR GUARDIAN

______ DATE