JOHN C. BAINES, D.D.S., F.A.G.D., P.A.

PATIENT INFORMATION AND HEALTH HISTORY

PATIENT

1. Name: _____ (LAST / FIRST / M.I.)
2. Address: _____ (STREET AND P.O. BOX)
   _____ (CITY / STATE / ZIP)
3. Email Address: _____
4. Phone: _____ (HOME) _____ (WORK)
   _____ (CELL)
5. Date of Birth: _____ (MO. / DAY / YR.)
6. Occupation: _____
7. Employer: _____ NAME (Business Name if Self-Employed)
   _____ (STREET / CITY / ZIP)
8. Social Security No.: _____-_____-_____
9. Driver's License No.: _____

PATIENT'S SPOUSE (OR PARENT)

10. Name: _____ (LAST / FIRST / M.I.)
11. Address: _____ (STREET AND P.O. BOX)
    _____ (CITY / STATE / ZIP)
12. Email Address: _____
13. Phone: _____ (HOME) _____ (WORK)
    _____ (CELL)
14. Date of Birth: _____ (MO. / DAY / YR.)
15. Occupation: _____
16. Employer: _____ NAME (Business Name if Self-Employed)
    _____ (STREET / CITY / ZIP)
17. Social Security No.: _____-_____-_____

19. Sex.: M____ F___
20. Check One:
    Married ___ Separated ___
    Unmarried ___ Widowed ___
21. Referred to our office by:
    _____ NAME
22. Have you or any member of your family been seen by us before?
    ☐ Yes ☐ No
    a. Which family members?
    _____ NAME
    _____ NAME
23. Do you have Dental Insurance?
    ☐ Yes ☐ No
    If so, name of company:
    _____

The following questions will be considered strictly confidential. Please answer each, and briefly explain "Yes" answers in space provided.

1. My last Physical Examination was: _____ Physician's Name, City, and State: _____
2. My last Dental Examination was: _____ Dentist's Name, City, and State: _____
3. My current health status is: ☐ Excellent ☐ Good ☐ Poor

	Yes	No	
4.	☐	☐	Presently under physician's care? For what? _____
5.	☐	☐	Women: Are you pregnant? Estimated date of delivery: _____
6.	☐	☐	Have you been hospitalized, for any reason, in the past 5 years? _____
7.	☐	☐	Are you taking any drugs, medicines, or injections? If so, list each one with reason underneath:

Medication _____ _____ _____ _____
Reason _____ _____ _____ _____

8. ☐ ☐ Are you allergic to or have you reacted adversely to any of the following medications?

Yes	No		Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Percodan	☐	☐	Erythromycin
☐	☐	Darvon	☐	☐	Local Anesthetic (Novacaine)	☐	☐	Valium
☐	☐	Nitrous Oxide Gas	☐	☐	Codeine	☐	☐	Penicillin

9. ☐ ☐	Are you allergic to any other medications, substances, latex, or metals? _____			
10. ☐ ☐	Have you ever had any complications or problems with previous dental treatment? _____			
11. ☐ ☐	Do you smoke or use tobacco? Amount? _____			
12. ☐ ☐	Have you ever been advised to take antibiotics prior to dental treatment? _____			

13. Circle any of the following which you have had or have at present:

Heart Failure	Heart Surgery	Liver Disease	Sickle Cell Disease	Hay Fever
Heart Disease or Attack	Anemia	Yellow Jaundice	Glaucoma	Sinus Trouble
Angina Pectoris	Stroke	Blood Transfusion	Chemotherapy	Allergies or Hives
High Blood Pressure	Kidney Trouble	Alcohol or Drug Addiction	Cancer or Leukemia	Diabetes
Heart Murmur	Ulcers	Hemophilia or Bleeding Problem	Venereal Disease	Thyroid Disease
Rheumatic Fever	A.I.D.S.	Fever Blisters	(Syphilis, Gonorrhea, etc.)	X-ray or Cobalt Treatment
Congenital Heart Lesions	Positive Blood Test for H.I.V.	Epilepsy or Seizures	Bruise Easily	Arthritis
Scarlet Fever	Hepatitis A (infectious)	Fainting or Dizzy Spells	Emphysema	Rheumatism
Artificial Heart Valve	Hepatitis B (serum)	Nervousness	Tuberculosis(TB)	Cortisone or Steroid Medicine
Heart Pacemaker	Hepatitis C	Psychiatric Treatment	Asthma	Artificial Joints (Hip, Knee, etc.)

14. Do you have any other illness or health problem not mentioned above? _____
15. Purpose of this Dental Visit? _____

I understand that I am financially responsible for all dental services rendered. My preference is ☐ cash ☐ check ☐ credit card (MC, DIS, or VISA).

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or my medicines change, I will inform the office at my next appointment without fail.

Signature: _____ Date: _____
(Responsible Party if Patient is a Minor)

Please answer *each* question, and briefly explain as necessary. We gratefully thank you for your completeness with these questions, as it will assist us in providing comprehensive and comfortable dental care.

1. Date of last *Full Mouth X-Rays:* _____
   (Machine that rotates around your head, or approximately 21 small films)
2. I consider my *current* dental health status as: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
3. How *often* do you brush your teeth? _____ Type of brush? _____
4. How *often* do you use dental floss? _____ Between *all* teeth? _____
5. Do you use any other materials or devices to clean plaque from your teeth or gums? _____
6. Have you been on a program of regularly scheduled preventive maintenance visits with your previous dentist? _____
   How often? _____ Date of last dental cleaning: _____

	Yes	No	
7.	☐	☐	Are you having any problems now? Explain: _____
8.	☐	☐	Do you wear *Dentures* (Partial or Full)? When were they made? _____
9.	☐	☐	If you wear dentures, any problems? Explain: _____
10.	☐	☐	Have you ever had, or been advised to have, *periodontal (gum)* treatments or surgery? When? _____
11.	☐	☐	Do your gums *bleed*, or feel tender or *irritated?* (circle) _____
12.	☐	☐	Are any teeth sensitive to hot, cold, sweets, or pressure? (circle) Where? _____
13.	☐	☐	Are you unhappy with the appearance or the color of your teeth? What would you like changed? _____
14.	☐	☐	If there was a simple, inexpensive way to whiten your teeth, would you be interested? _____
15.	☐	☐	Are you aware of *grinding* or *clenching* your teeth? When? _____
16.	☐	☐	Do you have any *missing teeth* which have not been replaced? If so, do you wish to have them replaced? _____
17.	☐	☐	Do you have *loose*, *tipped*, or *shifting* teeth? (circle) _____
18.	☐	☐	Have you worn *braces* on your teeth? *(orthodontics)* When? _____
19.	☐	☐	Do you have problems with teeth or fillings *breaking or chipping?* _____
20.	☐	☐	Are you aware of any sores, lumps, or swelling in your mouth or neck areas? _____
21.	☐	☐	Have your teeth or upper or lower jaw bones ever been involved in any traumatic blows or accidents? _____
22.	☐	☐	Have you ever had any problems with use of nitrous oxide gas or local dental anesthetics? _____
23.	☐	☐	Have you ever had problems with your "Jaw Joints", such as pain, muscle spasm, or inability to fully open or close? _____
24.	☐	☐	Have you ever been treated for chronic grinding, clenching, or T.M.J. problems? When? _____

Please list your dental priorities and goals, so that we will know how to best help you. Please also indicate any particular problems that may have occurred with past dental treatment that you would like us to be aware of and to avoid.

_____

_____

_____

_____

Signature: _____ Date: _____
(Responsible Party if Patient is a Minor)

DOCTOR'S NOTES

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_____

(11/03)