Town Center Dentistry and Orthodontics

Patient Information Sheet

Whom may we thank for referring you to our dental and orthodontic practice? _____

Name _____ ☐ Married ☐ Single ☐ Minor
Last First MI

Address_____ Date of Birth ___/___/___
Street Apt. # City State Zip Month Day Year

Telephone Home: ( ) _____-_____ Work: ( ) _____-_____ E-Mail _____

Place of Employment _____ Dental Insurance Co. _____

Group # _____ If Full Time Student, Name of School _____

Has any member of your family been treated in our practice? ☐ Yes ☐ No

Insured Information

Primary

Name: Last First MI

Address: Street City State Zip

Home Telephone # Work Telephone #

Date of Birth SS#

Employer Group #

Dental Insurance Co. Insurance Telephone #

Secondary

Name: Last First MI

Address: Street City State Zip

Home Telephone # Work Telephone #

Date of Birth SS#

Employer Group #

Dental Insurance Co. Insurance Telephone #

Acknowledgement and Authority

- The Information on this page and the dental/medical histories are correct to the best of my knowledge.
- I hereby authorize the Dentist to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.
- I grant the right to the dentist to release my dental/medical and other information about my dental treatment to third party payers and/or other health professionals, as appropriate under the circumstances.
- I also acknowledge full responsibility for the payment of fees for such services and agree to pay for them, in full, AT THE TIME OF SERVICE, unless other arrangement have been made in writing with a practice representative.
- I have received a copy of the HIPAA Privacy Policy as required by law.
- I grant the dental office permission to use the email address given above to contact me with respect to my dental care.

x _____

☐ Adult Pt. ☐ Father/ Mother ☐ Guardian

Person to Contact in Case of Emergency

Name_____

Address_____

Telephone # (____)_____-_____

Patient Health Information

TOWNCENTER DENTISTRY AND ORTHODONTICS

Name:_____ Date: _____

Physician's Name:_____ Date Last Seen:_____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Have you ever had any surgical procedures? ❑ Yes ❑ No
Please list each one: _____

Are you taking any medications? ❑ Yes ❑ No
Please list each one: _____

Do you use tobacco in any form?: ❑ Yes ❑No

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
❑	❑	Abnormal Bleeding	❑	❑	HIV+ Aids	❑	❑	Stroke
❑	❑	Alcohol Abuse	❑	❑	Heart Attack: When?___	❑	❑	Thyroid Problems
❑	❑	Allergies	❑	❑	Heart Murmur	❑	❑	Tuberculosis
❑	❑	Angina Pectoris	❑	❑	Heart Surgery			
❑	❑	Arthritis	❑	❑	Hepatitis B			
❑	❑	Artificial Heart Valve	❑	❑	Hepatitis C			
❑	❑	Asthma	❑	❑	High Blood Pressure			
❑	❑	Cancer	❑	❑	Joint Replacement			
❑	❑	Chemotherapy	❑	❑	Kidney Problems			
❑	❑	Congenital Heart Defect	❑	❑	Liver Disease			
❑	❑	Diabetes	❑	❑	Low Blood Pressure			
❑	❑	Drug Abuse	❑	❑	Pacemaker			
❑	❑	Emphysema	❑	❑	Psychiatric Problems			
❑	❑	Epilepsy	❑	❑	Rheumatic Fever			
❑	❑	Fainting Spells	❑	❑	Seizures			
❑	❑	Frequent Headaches	❑	❑	Sexually Transmitted Disease			
❑	❑	Glaucoma	❑	❑	Sinus Problems			

Yes	No	Allergies
❑	❑	Aspirin
❑	❑	Codeine
❑	❑	Latex
❑	❑	Penicillin
❑	❑	Tetracyline

Yes	No	If Female,
❑	❑	Are you taking Birth Control pills?
❑	❑	Are you pregnant? If so, # of weeks ___
❑	❑	Are you nursing?

Is there any other disease/condition not listed above? _____

Please check if you have had or have any of the following:

❑ Bad breath
❑ Bad tastes
❑ Bite nails/objects
❑ Bleeding gums
❑ Chew on one side
❑ Clenching/grinding teeth
❑ Clicking/popping of jaw
❑ Difficulty chewing
❑ Dry mouth
❑ Gag easily
❑ Infection in gums
❑ Jaw pain/soreness
❑ Loose teeth
❑ Mouth sores
❑ Missing teeth
❑ Sensitive gums
❑ Sensitive to: ❑Hot ❑Cold ❑Sweets
❑ Stained teeth

I understand that the information that I have given today is the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ **Date:** _____

Medical History Update

Date: _____ ❑ Changes: _____ ❑ None Signature: _____

Date: _____ ❑ Changes: _____ ❑ None Signature: _____

Date: _____ ❑ Changes: ❑ None Signature: _____