



## INITIAL PATIENT HISTORY FORM

Date \_\_\_\_\_ Do you have any allergies? \_\_\_\_\_ If so, list here: \_\_\_\_\_

### Patient Information

Patient's Name _____	Date of Birth _____	Sex _____
Address _____		Home Phone _____
Patient's School _____		SS # _____
Patient's Dentist _____		Patient's Physician _____
Hobbies _____		
If patient is minor, give parent's or guardian's name _____		

### Responsible Party Information *(for patients under the age of 18)*

Name _____		Marital Status _____	
Residence _____			
Mailing address (if different) _____			
Home Phone _____		Cell Phone _____	
Work Phone _____			
Social Security # _____		Birth Date _____	
Relationship to patient _____			
Employer _____		Occupation _____	
No. Years Employed _____			
Spouse's name _____		Relationship to Patient _____	
Employer _____		Occupation _____	
No. Years Employed _____			
Social Security # _____		Birth Date _____	
Daytime Phone _____			

### Dental Insurance Information

Insured's Name _____		Insured's SS # or ID # _____	
Insurance Company _____		Group No. _____	
		Local No. _____	
Insured's Employer _____		Insured's Birth Date _____	
Insurance Co. Address _____			
Insurance phone # _____			
Do you have dual coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following:			
Insured's Name _____		Insured's SS# or ID# _____	
Insurance Company _____		Group No. _____	
		Local No. _____	
Insurance Co. Address _____			
Insured's Employer _____		Insured's Birth Date _____	

I authorize the following:

- 1) The release of dental records or other information to process any claims filed by this office for services rendered.
- 2) Payment of dental benefits to Marcia K. Beck, D.D.S., M.S.
- 3) This copy of my signature to be sent with my insurance claims.

(Primary) Signature on File \_\_\_\_\_ Date \_\_\_\_\_

(Secondary) Signature on File \_\_\_\_\_ Date \_\_\_\_\_

## Dental History

Do you have any of the following?

- \_\_\_\_\_ Any family members who have had orthodontics.
- \_\_\_\_\_ Teeth sensitive to hot/cold.
- \_\_\_\_\_ Injuries to your teeth, face, jaw or mouth.
- \_\_\_\_\_ Bleeding gums, bad taste in mouth.
- \_\_\_\_\_ Root canals, crowns or bridges.
- \_\_\_\_\_ Suck your thumb and / or fingers.
- \_\_\_\_\_ Any clicking, popping or pain of the jaw, joints (TMJ).
- \_\_\_\_\_ Any missing teeth or extra teeth.
- \_\_\_\_\_ Treatment with Speech Therapy

Date of most recent dental exam \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

- Manual toothbrush                       battery operated toothbrush

## Medical History

Do you have any of the following? Please  $\checkmark$  if yes

- |  |  |
|--|--|
| <input type="checkbox"/> Heart Disease                       | <input type="checkbox"/> Allergies _____                 |
| <input type="checkbox"/> Heart Murmur                        | <input type="checkbox"/> Allergy to Latex                |
| <input type="checkbox"/> Rheumatic Fever                     | <input type="checkbox"/> Sleep apnea / snoring           |
| <input type="checkbox"/> High blood pressure                 | <input type="checkbox"/> Tonsil or Adenoid Problems      |
| <input type="checkbox"/> Diabetes                            | <input type="checkbox"/> Tendency to be a mouth breather |
| <input type="checkbox"/> Blood Disorder                      | <input type="checkbox"/> Epilepsy                        |
| <input type="checkbox"/> AIDS or Immune Suppressive Disorder | <input type="checkbox"/> Tuberculosis or lung disease    |
| <input type="checkbox"/> Hepatitis A, B, C, or D             |  |

Do any conditions exist other than those mentioned above? \_\_\_\_\_

Is the patient taking medications and what are they? \_\_\_\_\_

Is the patient taking any preventive osteoporosis medications? If so, which one (s)? \_\_\_\_\_

What is the main thing you would like to find out by coming to see Dr. Beck and what would you like to change about your smile? \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

How did you hear about our office? (please circle)

Referring Doctor	Advertisement	Telephone Book	Friend
Orthodontic website	Co-worker	Insurance website	Our sign

## Contact Information

I prefer to be contacted during the day by

- |   |   |
|---|---|
| <input type="checkbox"/> Cell phone _____   | <input type="checkbox"/> Home phone _____ |
| <input type="checkbox"/> Office phone _____ | <input type="checkbox"/> Email _____      |
| <input type="checkbox"/> Other _____        |   |

May we use patient's photo for educational and promotional purposes?     Yes     No

Signature (Parent's signature if minor) \_\_\_\_\_

Date: \_\_\_\_\_