Patient form for Sheila Birth, D.D.S., M.S. and Charles Stewart, D.D.S., MDIV - professionalsmiles.com

Last

First

Initial

Birthdate

S.S. #

Address

City

State

Zip

Phone

Party Responsible or Guardian

Phone

Email

DL# of Rep, Party

S.S.# of Rep, Party

Employment

Position

Business Phone

Nearest Relative not living with you

Relation

Address

City

State

Zip

Phone

Dental Insurance No.1

Group #

Company Name

Policy Holder

S.S.#

Dental Insurance No.2

Group #

Company Name

Policy Holder

S.S.#

I authorize release of any information necessary to process dental claim.

____

I hereby authorize payment directly to the below named Dentist of the Group Insurance otherwise payable to me.

____

Referred by: [ ]

Date of Last Dental Exam & Cleaning [ ]

Marital Status [ ]

Name of general dentist [ ]

YES	NO	Have you had any of the following:
☐	☐	Hepatitis
☐	☐	Liver Disease
☐	☐	Epilepsy Convulsions
☐	☐	Seizures
☐	☐	Rheumatic Fever
☐	☐	Kidney
☐	☐	Bladder Disease
☐	☐	Diabetes
☐	☐	Tuberculosis
☐	☐	Emphysema
☐	☐	Asthma
☐	☐	Shortness of Breath
☐	☐	Swollen Ankles
☐	☐	Chest Pains
☐	☐	Heart Trouble
☐	☐	High/Low Blood Pressure
☐	☐	Stroke
☐	☐	Thyroid Trouble
☐	☐	Psychiatric Treatment
☐	☐	Arthritis
☐	☐	Rheumatism
☐	☐	Venereal Disease
☐	☐	Glaucoma
☐	☐	Chemotherapy/Radiation Therapy
☐	☐	Sinus Problem/Hay Fever
☐	☐	Allergies
☐	☐	Problem at Birth
☐	☐	Heart Murmur
☐	☐	Sickle Cell Anemia
☐	☐	Bleeding/Hemophilia

YES	NO	
☐	☐	Blood Transfusion
☐	☐	AIDS/HIV positive
☐	☐	Cancer
☐	☐	Cleft Lip/Palate
☐	☐	Speech Problems
☐	☐	Hearing Problems
☐	☐	Eye Problems/Contact Lenses
☐	☐	Tonsil/Adenoid Problems

YES	NO	If you are female, are you?:
☐	☐	Pregnant
☐	☐	Taking Birth Control Pills
☐	☐	Taking Hormone Medication

Are you presently under the care of a physician?

YES	NO	If so, for what and date of last office appointment:
☐	☐	

[ ]

YES NO Have you ever been told that you are allergic to a drug?

☐ ☐

YES NO Have you ever had a bad reaction to a drug?

☐ ☐

If yes to either, please explain:

YES NO Have you ever had a bleeding problem?

☐ ☐

YES NO Have you ever had trouble with an extraction?

☐ ☐

If yes to either, please explain:

Are you presently taking any drugs or medications?

YES NO if yes, please list:

☐ ☐

YES	NO	
☐	☐	Do you have difficulty opening your mouth widely?
☐	☐	Have you ever received a severe blow to your head or jaw?
☐	☐	Does it cause pain to open your jaw widely?
☐	☐	Do you ever hear popping or clicking sounds from your jaw joints?
☐	☐	Are you presently in any pain from your jaw joints or muscles?
☐	☐	Are you taking any tranquilizers, muscle relaxants, or antidepressants?

What is the main problem that brought you to our office?

Please add anything about your medical or dental history you feel is important for us to know about?

Doctor's Signature and Date:

____