

## PATIENT INFORMATION

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_  
 Birth date \_\_\_\_\_ Single Married Widowed Separated Divorced  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Work Phone \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_

### HEALTH AND DENTAL HISTORY

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_  
 Date of last visit \_\_\_\_\_ Have you had any serious illnesses or operations?  Y  N  
 If yes, please describe \_\_\_\_\_  
 Are you currently under physician care?  Y  N If yes, describe \_\_\_\_\_  
 Women: Are you pregnant?  Y  N Nursing?  Y  N Taking Birth control pills?  Y  N  
 Have you ever had any cosmetic procedures?  Y  N If yes, describe \_\_\_\_\_

Check if you have had any of the following:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Heart Problems         | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Abnormal Bleeding         |
| <input type="checkbox"/> Heart Murmur           | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Mitral Valve Prolapse  | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Rheumatic/Scarlet fever   |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Epilepsy/Seizures    | <input type="checkbox"/> Chemical Dependency       |
| <input type="checkbox"/> Pacemaker              | <input type="checkbox"/> Anemia               | <input type="checkbox"/> Tobacco Habit             |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Venereal Disease          |
| <input type="checkbox"/> Respiratory Disease    | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Herpes                    |
| <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Neurological Disorders    |
| <input type="checkbox"/> AIDS/HIV               | <input type="checkbox"/> Artificial Joints    | <input type="checkbox"/> Psychiatric/Psychological |

**DENTAL CONCERNS:** Please check if you have had or now have any of the following:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Jaw Pain                   | <input type="checkbox"/> Congested Ears         |
| <input type="checkbox"/> Facial Pain              | <input type="checkbox"/> Jaw Popping                | <input type="checkbox"/> Ringing Ears           |
| <input type="checkbox"/> Neck Ache                | <input type="checkbox"/> Clenching                  | <input type="checkbox"/> Dizziness              |
| <input type="checkbox"/> Bells Palsy              | <input type="checkbox"/> Grinding                   | <input type="checkbox"/> Sensitive Teeth        |
| <input type="checkbox"/> Loose Teeth              | <input type="checkbox"/> Limited Opening            | <input type="checkbox"/> Difficulty Chewing     |
| <input type="checkbox"/> Tingling in fingers      | <input type="checkbox"/> Difficulty Swallowing      | <input type="checkbox"/> Trigeminal Neuralgia   |
| <input type="checkbox"/> Insomnia/frequent waking | <input type="checkbox"/> Gums Bleed                 | <input type="checkbox"/> Halitosis (bad breath) |
| <input type="checkbox"/> Floss shreds when using  | <input type="checkbox"/> Food catches between teeth | <input type="checkbox"/> Chew Tobacco           |

Allergies to medication or Latex \_\_\_\_\_

I authorize Dr. Overton to administer medications and perform diagnostic and photographic procedures as necessary for proper dental care. I grant the right to the dentist to release my dental /medical histories and other information about my dental treatment to third party payers and other health professionals.

Signature \_\_\_\_\_ Date \_\_\_\_\_