ERICA S. CONWAY D.D.S.

PATIENT HISTORY AND INFORMATION
WELCOME. SO THAT WE MAY PROVIDE YOU WITH THE BEST POSSIBLE CARE,
PLEASE COMPLETE BOTH SIDES OF THIS FORM
ALL INFORMATION IS COMPLETELY CONFIDENTIAL

PATIENT NAME _____ AGE _____ BIRTHDATE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
EMPLOYED BY: _____ IF STUDENT, SCHOOL _____
HOME PHONE NUMBER _____ WORK PHONE NUMBER _____ CELL _____
YOUR SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____
IF MARRIED, NAME OF SPOUSE _____ SPOUSE'S BIRTH DATE _____
SPOUSE'S SOCIAL SECURITY # _____ SPOUSE EMPLOYED BY _____

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING

PRIMARY CARRIER _____ SECONDARY CARRIER _____
INSURANCE CO. ADDRESS _____ INS. CO ADDRESS _____
GROUP# /LOCAL UNION# _____ GROUP NUMBER/LOCAL UNION # _____
INSURED PERSON _____ INSURED PERSON _____
SS# _____ BIRTHDATE _____ SS# _____ BIRTHDATE _____
EMPLOYER _____ EMPLOYER _____

ACCOUNT INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT _____ RELATIONSHIP _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE NUMBER _____ WHO REFERRED YOU TO US? _____
PERSON TO NOTIFY IN CASE OF EMERGENCY _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
CLOSEST RELATIVE NOT LIVING WITH YOU _____ PHONE # _____

MEDICAL HISTORY

PHYSICIAN'S NAME _____ PHONE # _____
ADDRESS _____
KAISER # _____

PLEASE CIRCLE YES OR NO

HAVE YOU BEEN UNDER THE CARE OF A MEDICAL DOCTOR DURING THE PAST 2 YEARS? YES NO
IF YES, FOR WHAT? _____
ARE YOU TAKING ANY DRUGS, MEDICATION OR PILLS AT PRESENT? YES NO
IF YES, PLEASE LIST NAMES AND DOSAGES _____

HAVE YOU EVER BEEN HOSPITALIZED OR HAVE YOU HAD ANY OPERATIONS? YES NO
IF YES, FOR WHAT? _____

DO YOU HAVE OR HAD ANY OF THE FOLLOWING? CIRCLE YES OR NO TO EACH ITEM

HEART (SURGERY, DISEASE, ATTACK) YES NO
CHEST PAIN YES NO
CONGENTIAL HEART DISEASE YES NO
HEART MURMUR YES NO
HIGH BLOOD PRESSURE YES NO
MITRAL VALVE PROLAPSE YES NO
HEART PACEMAKER YES NO
RHEUMATIC FEVER YES NO
ARTHRITIS/RHEUMATISM YES NO
CORTISONE MEDICINE YES NO
SWOLLEN ANKLES YES NO
STROKE YES NO
DIET (SPECIAL/RESTRICTED) YES NO
ARTIFICIAL JOINTS (HIP, KNEE, ETC.) YES NO
ULCERS YES NO
DIABETES YES NO

THYROID PROBLEMS YES NO
GLAUCOMA YES NO
CONTACT LENSES YES NO
EMPHYSEMA YES NO
CHRONIC COUGH YES NO
TUBERCULOSIS YES NO
ASTHMA YES NO
HAY FEVER YES NO
LATEX SENSITIVITY YES NO
ALLERGIES OR HIVES YES NO
SINUS TROUBLE YES NO
RADIATION THERAPY YES NO
CHEMOTHERAPY YES NO
TUMORS YES NO
HEPATITIS A (INFECTIOUS) B (SERUM) YES NO
VENEREAL DISEASE YES NO

A.I.D.S. YES NO
H.I.V. POSITIVE YES NO
COLD SORES/FEVER BLISTERS YES NO
BLOOD TRANSFUSION YES NO
HEMOPHILIA YES NO
SICKLE CELL DISEASE YES NO
BRUISE EASILY YES NO
LIVER DISEASE YES NO
YELLOW JAUNDICE YES NO
NEUROLOGICAL DISORDERS YES NO
EPILEPSY OR SEIZURES YES NO
FAINTING OR DIZZY SPELLS YES NO
NERVOUS/ANXIOUS YES NO
PSYCHIATRIC/PSYCHOLOGICAL CARE YES NO
ARE YOU SENSITIVE TO ANY METALS YES NO

DO YOU SMOKE/CHEW TOBACCO? _____ PACKS/DAY _____ HOW MANY YEARS? _____

HAVE YOU EVER TAKEN PHEN/FEN, REDUX, OR BISPHOSPHONATES (ie. Fosamax)? ..... YES NO

ARE YOU AWARE OF HAVING AN ALLERGIC REACTION TO ANY MEDICATION OR SUBSTANCE? ..... YES NO

IF YES, PLEASE LIST _____

HAVE YOU EVER HAD A SERIOUS HEAD OR NECK INJURY? ..... YES NO

DO YOU HAVE OR HAVE YOU HAD ANY DISEASE, CONDITION OR PROBLEM NOT LISTED? ..... YES NO

IF YES PLEASE LIST _____

WOMEN, PREGNANT ..... YES, DATE DUE _____ NO NURSING ..... YES NO

TAKING BIRTH CONTROL PILLS ..... YES NO

MEDICAL HISTORY REVIEW (BY DENTIST OR STAFF)

DENTAL HISTORY

PREVIOUS DENTIST NAME _____ PHONE NUMBER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW OFTEN DO YOU HAVE DENTAL EXAMINATIONS? _____ LAST DENTAL EXAM? _____

LAST FULL MOUTH XRAYS _____ LAST BITEWING XRAYS _____

HOW OFTEN DO YOU BRUSH YOUR TEETH? _____ FLOSS? _____

WHAT OTHER DENTAL AIDS DO YOU USE? _____

DO YOU HAVE ANY DENTAL PROBLEMS? IF SO, PLEASE DESCRIBE _____

ARE YOU TEETH SENSITIVE TO HOT? ..... YES NO. HAVE YOU EVER HAD: .....

TO COLD? ..... YES NO ORTHODONTIC TREATMENT? ..... YES NO

TO SWEETS? ..... YES NO ORAL SURGERY? ..... YES NO

TO PRESSURE OR CHEWING? ..... YES NO. PERIODONTAL TREATMENT? ..... YES NO

DO YOU HAVE BAD TASTE IN YOUR MOUTH? ..... YES NO BITE ADJUSTMENT? ..... YES NO

DO YOUR GUMS BLEED OR HURT? ..... YES NO. SERIOUS INJURY TO MOUTH ..... YES NO

HAVE YOU NOTICED ANY LOOSE TOOTH? ..... YES NO .....

DOES FOOD TEND TO BECOME CAUGHT IN BETWEEN YOUR TEETH? ..... YES NO

DO YOU HAVE ANY PAIN, CLICKING OR POPPING OF YOUR JAW, EAR OR SIDE OF FACE? ..... YES NO

DO YOU HAVE ANY DIFFICULTY IN OPENING OR CLOSING YOUR MOUTH OR CHEWING? ..... YES NO

ARE YOU AWARE OF CLENCHING OR GRINDING YOUR TEETH? ..... YES NO

ARE YOUR JAWS "TIRED" OR "TENSE" ESPECIALLY IN THE MORNING? ..... YES NO

ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH? ..... YES NO

ARE YOU ABLE TO SATISFACTORILY CHEW YOUR FOOD? ..... YES NO

ARE YOU NERVOUS ABOUT HAVING DENTAL TREATMENT? ..... YES NO

HAVE YOU EVER HAD AN UNUSUAL OR UNPLEASANT EXPERIENCE IN A DENTAL OFFICE? ..... YES NO

IS THERE ANYTHING YOU WOULD LIKE TO ADD? ..... YES NO

ARE YOU INTERESTED IN TEETH BLEACHING? ..... YES NO

ACKNOWLEDGMENTS AND AUTHORITY

I CONSENT TO TREATMENT AS NECESSARY OR DESIRABLE TO THE PATIENT FIRST NAMED ABOVE, INCLUDING BUT NOT RESTRICTIVE TO WHATEVER DRUGS, MEDICINE, PERFORMANCE OR OPERATIONS AND CONDUCT OF LABORATORY, X-RAY, OR OTHER STUDIES THAT MAY BE USED BY THE ATTENDING DOCTOR, OR HER ASSISTANT. I HAVE ANSWERED ALL OF THE QUESTIONS TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY THE DENTIST OF ANY CHANGE IN MY HEALTH OR MEDICATIONS.

UNLESS OTHER ARRANGEMENTS ARE MADE WITH THE DENTIST OR THE RECEPTIONIST, I ALSO ACKNOWLEDGE FULL RESPONSIBLILITY FOR PAYMENT OF SUCH SERVICES AND AGREE TO PAY THEM, IN FULL, AT THE TIME OF SERVICE.

WE RESERVE THE RIGHT TO CHARGE FOR APPOINTMENTS CANCELLED WITHOUT 24 HOUR NOTICE. OUR FAILED APPOINTMENT FEE IS $50.00.

I HAVE RECEIVED THE PRIVACY PRACTICES, DENTAL MATERIALS FACT SHEET & FINANCIAL POLICY FORMS.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

DOCTOR'S SIGNATURE _____ DATE _____