Parsell Family
DENTAL

PATIENT INFORMATION	
NAME ______________	BIRTHDATE ______________
ADDRESS ______________	**CIRCLE APPROPRIATE SELECTION:** MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED
CITY ______________ STATE ______________ ZIP ______________	
STUDENT/SCHOOL ______________	HOME PHONE ______________
OCCUPATION/EMPLOYER______________	WORK PHONE ______________
SEX F M SPOUSE______________	CELL PHONE ______________
EMAIL ______________	PREFFERED METHOD OF CONTACT HOME CELL EMAIL
WHOM MAY WE THANK FOR REFERRING YOU? ______________	TEXTING? YES NO

RESPONSIBLE PARTY/ INSURANCE INFORMATION	
PERSON RESPONSIBLE FINANCIALLY ______________	BIRTHDATE ______________
RELATIONSHIP TO PATIENT ______________	HOME PHONE ______________
ADDRESS ______________	WORK PHONE ______________
CITY ______________ STATE ______________ ZIP ______________	CELL PHONE ______________
EMPLOYER ______________	SS NUMBER ______________
INSURANCE COMPANY ______________	MEMBERS ID ______________
	GROUP NUMBER ______________
WHO DO WE CONTACT IN CASE OF AN EMERGENCY? ______________	INSURANCE PHONE ______________
EMERGENCY PHONE ______________ RELATIONSHIP______________	

ADDITIONAL INSURANCE	
NAME OF INSURED ______________	BIRTHDATE ______________
RELATIONSHIP TO PATIENT ______________	SS NUMBER ______________
INSURANCE COMPANY ______________	MEMBERS ID ______________
ADDRESS ______________	GROUP NUMBER ______________
CITY ______________ STATE ______________ ZIP ______________	INSURANCE PHONE ______________

PATIENT MEDICAL HISTORY

PHYSICIAN NAME ____

- ARE YOU UNDER THE CARE OF A PHYSICIAN? YES NO
- HAVE YOU BEEN HOSPITALIZED IN THE LAST FIVE YEARS? YES NO
- DO YOU USE TOBACCO? YES NO
- DO YOU VAPE? YES NO
- DO YOU USE ALCOHOL? YES NO
- DO YOU HAVE ANY CHEMICAL DEPENDENCY? YES NO
- DO YOU WEAR CONTACTS? YES NO
- DO YOU HAVE ANY ALLERGIES? YES NO
  EXPLAIN: ____

- HAVE YOU EVER HAD A REACTION TO ANESTHETIC? YES NO
  EXPLAIN: ____

  ____

- ARE YOU TAKING MEDICATIONS? INCLUDING OVER THE COUNTER AND PRESCRIPTION. YES NO

PLEASE LIST: ____

____

____

____

____

NEED MORE SPACE? USE THE BACK OF THIS PAGE

PHYSICIAN PHONE ________________

DATE OF LAST EXAM

____

ARE ON ANY MEDICATION FOR OSTEOPOROSIS? YES NO

WOMEN ONLY:

- ARE YOU PREGNANT? Y N
- ARE YOU NURSING? Y N
- ARE YOU TAKING BIRTH CONTROL PILLS Y N

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS ABOUT YOURSELF:

	YES	NO		YES	NO
HIGH BLOOD PRESSURE	___	___	FREQUENTLY TIRED	___	___
HEART ATTACK	___	___	ANEMIA	___	___
RHEUMATIC FEVER	___	___	EMPHYSEMA	___	___
SWOLLEN ANKLES	___	___	CANCER	___	___
FAINTING/SEIZURES	___	___	ARTHRITIS	___	___
ASTHMA	___	___	JOINT REPLACEMENT	___	___
LOW BLOOD PRESSURE	___	___	CHEST PAINS	___	___
EPILEPSY/CONVULSIONS	___	___	SHORT OF BREATH	___	___
LEUKEMIA	___	___	STROKE	___	___
DIABETES	___	___	HAY FEVER/ALLERGIES	___	___
HEART DISEASE	___	___	TUBERCULOSIS	___	___
CARDIAC PACEMAKER	___	___	RADIATION/CHEMO	___	___
HEART MURMUR	___	___	GLAUCOMA	___	___
ANGINA	___	___	LIVER DISEASE	___	___
COPD	___	___	CORTIZONE TREATMENT	___	___
ARTIFICAL HEART VALVE	___	___	KIDNEY DISEASE	___	___
AIDS/HIV INFECTION	___	___	STD'S	___	___
THYROID PROBLEMS	___	___	HEPATITIS A, B OR C	___	___
ULCERS	___	___	RESPIRATORY PROBLEMS	___	___

OTHER ____

____

ARE YOU ON COUMADIN? YES NO

ANY BLEEDING ABNORMALLY WITH EXTRACTIONS OR SURGERY? YES NO

PATIENT NAME ____

PATIENT DENTAL HISTORY

DATE OF LAST DENTAL EXAM ____

1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? YES NO
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? YES NO
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? YES NO
4. DO YOU FEEL PAIN IN ANY OF YOUR TEETH? YES NO
5. DO YOU HAVE ANY SORES OR LUMPS IN YOUR MOUTH? YES NO
6. HAVE YOU EVER SUFFERED TRAUMA TO YOUR FACE MOUTH OR JAW? YES NO
7. DOES YOUR JAW EVER CLICK, POP, CRACKLE OR ACHE? YES NO
8. DO YOU HAVE PAIN IN YOUR JAW JOINT, EAR OR SIDE OF THE FACE? YES NO
9. DO YOU HAVE DIFFICULTY OPENING OR CLOSING YOUR MOUTH? YES NO
10. DO YOU HAVE DIFFICULTY CHEWING? YES NO
11. DO YOU ONLY CHEW ON ONE SIDE? YES NO
12. DO YOU HAVE DRY MOUTH? YES NO
13. DO YOU HAVE FREQUENT HEADACHES? YES NO
14. DO YOU CLENCH OR GRIND YOUR TEETH? YES NO
15. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? YES NO
16. HAVE YOU HAD PROBLEMS WITH PREVIOUS DENTAL WORK? YES NO
17. DO YOU HAVE ANY LOOSE TEETH OR BROKEN FILLING? YES NO
18. HAVE YOU EVER HAD BRACES? YES NO
19. DO YOU USE ANY TYPE OF MOUTH RINSE? YES NO
20. HOW MANY TIMES A DAY DO YOU BRUSH YOUR TEETH? __________
21. HOW OFTEN DO YOU FLOSS? __________
22. DO YOU USE A MANUAL BRUSH OR ELECTRIC? __________

GOALS FOR YOUR MOUTH, TEETH AND SMILE:

____

____

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD THAT BE?

____

____

WOULD YOU BE INTERESTED IN WHITENING? YES NO

WOULD YOU BE INTERESTED IN STRAIGHTENING YOUR TEETH WITH CLEAR ALIGNERS? YES NO

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

____ ____________________

PATIENT SIGNATURE DATE

____

PRINT NAME

____

DENTIST SIGNATURE

____

DATE