

Pharmacy Name \_\_\_\_\_ Phone \_\_\_\_\_  
So that we may provide you with the best possible care, please complete both sides of this medical/dental history form.

(PLEASE PRINT)

Date \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

Patient Name \_\_\_\_\_ Patient Is  Policy Holder  Responsible Party (Preferred Name \_\_\_\_\_)

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell/Pager \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Social Security # \_\_\_\_\_ Driver's Lic.# \_\_\_\_\_

Sex:  Male  Female Age \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Employed By \_\_\_\_\_

Occupation \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Tel. \_\_\_\_\_

Spouse Name \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_

Employed By \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Tel. \_\_\_\_\_

Social Security # \_\_\_\_\_

**Person Responsible For Account**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Hm# ( ) \_\_\_\_\_ DL# \_\_\_\_\_

Employer: \_\_\_\_\_

Wk# ( ) \_\_\_\_\_ Ext: \_\_\_\_\_ SS# \_\_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_ Tel. \_\_\_\_\_

**Medical Insurance Primary Carrier**

Insured's Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group Number \_\_\_\_\_ ID Number \_\_\_\_\_ Birthdate \_\_\_\_\_

Insured's Employer \_\_\_\_\_

**Medical Insurance Secondary Carrier**

Insured's Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group Number \_\_\_\_\_ ID Number \_\_\_\_\_ Birthdate \_\_\_\_\_

Insured's Employer \_\_\_\_\_

**DENTAL HISTORY**

Circle "Yes" or "No" to each item.

<p><b>Do you:</b></p> <p>Clench or grind your teeth while awake or asleep? ..... Yes No</p> <p>Bite your lips or cheeks regularly? ..... Yes No</p> <p>Hold foreign objects with your teeth? ..... Yes No (pencils, pipe, pins, nails, fingernails)</p> <p>Mouth breathe while awake or asleep? ... Yes No</p> <p>Have tired jaws, especially in the morning? ..... Yes No</p> <p>Smoke/chew tobacco? ..... Yes No How much? _____</p> <p><b>Have you ever had:</b></p> <p>Orthodontic treatment? ..... Yes No</p> <p>Oral surgery? ..... Yes No</p> <p>Periodontal treatment? ..... Yes No</p> <p>A bite plate or mouth guard? ..... Yes No</p> <p>Your teeth ground or the bite adjusted? ... Yes No</p> <p>A serious injury to the mouth or head?.. Yes No If yes, please describe, including cause. _____</p>	<p><b>Are any of your teeth sensitive to:</b></p> <p>Hot or cold ..... Yes No</p> <p>Sweet ..... Yes No</p> <p>Biting or chewing ..... Yes No</p> <p>Have you noticed any mouth odors or bad tastes? ..... Yes No</p> <p>Do you frequently get cold sores, blisters or any other oral lesions? ..... Yes No</p> <p>Do your gums bleed or hurt? ..... Yes No</p> <p>Have your parents experienced gum disease or tooth loss? ..... Yes No</p> <p>Have you noticed any loose teeth or a change in your bite? ..... Yes No</p> <p>Do you have difficulty in chewing on either side of the mouth? ..... Yes No</p> <p>Does food tend to become caught in between your teeth? ..... Yes No</p> <p>If yes, where? _____</p>	<p><b>Have you ever experienced:</b></p> <p>Clicking or popping of the jaw? ..... Yes No</p> <p>Pain? (joint, ear, side of face) ..... Yes No</p> <p>Difficulty in opening or closing the mouth? . Yes No</p> <p>Headaches, neckaches or shoulder aches? ..... Yes No</p> <p>Sore muscles (neck, shoulders)? ..... Yes No</p> <p>Are you happy with your smile? ..... Yes No</p> <p>Are you pleased with the color of your teeth? Yes No</p> <p>Would you like to keep all of your teeth all of your life? ..... Yes No</p> <p>Do you feel nervous about having dental treatment? ..... Yes No</p> <p>If yes, what is your biggest concern? _____</p> <p>Have you ever had an upsetting dental experience? ..... Yes No</p> <p>If yes, please describe _____</p>
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