

Welcome to ELIZABETH PATINO DMD, PA's dental practice.

Please complete the following confidential form, in ink, to the best of your knowledge.

We are committed to excellence in care and *thank you* for choosing us as your dental healthcare provider.

### Patient Information

Name \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Status:  Minor  Divorced  
Work Phone \_\_\_\_\_  Single  Widowed  
Cell phone \_\_\_\_\_  Married  Separated  
E-mail \_\_\_\_\_ *Student only:* Name of School \_\_\_\_\_ Time:  Full  Part

Emergency contact: _____ _____ _____
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### Responsible Party

Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ E-mail \_\_\_\_\_ Date employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Work/Home Phone \_\_\_\_\_

### Insurance Information: No Insurance

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ E-mail \_\_\_\_\_ Date employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

*Primary Insurance Carrier* \_\_\_\_\_ Member ID \_\_\_\_\_ Group# \_\_\_\_\_  
Address of Ins Carrier \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max Annual Benefit? \_\_\_\_\_

*Secondary Insurance Carrier* \_\_\_\_\_ Member ID \_\_\_\_\_ Group# \_\_\_\_\_  
Address of Ins. Carrier \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max Annual Benefit? \_\_\_\_\_

### Dental History

Name of previous Dentist \_\_\_\_\_ Date of last dental visit \_\_\_\_\_

- |   |                             |                              |
|---|-----------------------------|------------------------------|
| Do your gums bleed while brushing or flossing?                  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Are your teeth sensitive to hot or cold liquids/foods?          | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Are your teeth sensitive to sweet or sour liquids/foods?        | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you feel pain to any of your teeth?                          | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you have any sores or lumps in or near your mouth?           | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Have you had any head, neck or jaw injuries?                    | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Have you ever experienced any jaw joint problems (TMJ)?         | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you have frequent headaches?                                 | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you clench or grind your teeth?                              | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you bite your lips or cheeks frequently?                     | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Have you ever had any difficult extractions in the past?        | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Have you ever had any prolonged bleeding following extractions? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Have you had any orthodontic treatment?                         | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you wear dentures or partials?                               | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Have you ever received oral hygiene instructions?               | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you like your smile?   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

**Medical History**

Primary Physician \_\_\_\_\_ Office Phone Number \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

Are you under any medical treatment now?  No  Yes: \_\_\_\_\_  
Have you ever had a serious illness or operation?  No  Yes: \_\_\_\_\_  
Have you been hospitalized within the last 5 yrs?  No  Yes: \_\_\_\_\_  
Are you taking non-prescription medication(s)?  No  Yes: \_\_\_\_\_  
Are you taking any medication(s)?  No  Yes: \_\_\_\_\_

Do you use controlled substances?  No  Yes  
Do you use tobacco?  No  Yes  
Do you drink alcoholic beverages?  No  Yes  
Does your occupation expose you to blood?  No  Yes  
Have you ever taken Fen-Phen/Redux?  No  Yes  
Do you have a persistent cough?  No  Yes  
Are you wearing contact lenses?  No  Yes

*Women only:*

Are you pregnant or think you might be?  No  Yes  
Are you taking oral contraceptives?  No  Yes  
Are you nursing?  No  Yes

**Are you allergic to any of the following?**  
Local Anesthetics  No  Yes  
Antibiotics  No  Yes  
Sulfa Drugs  No  Yes  
Barbiturates  No  Yes  
Sedatives  No  Yes  
Iodine  No  Yes  
Aspirin  No  Yes  
Metals  No  Yes  
Latex Rubber  No  Yes  
Others: \_\_\_\_\_

Do you have or have you had any of the following?

	No	Yes		No	Yes		No	Yes
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/ Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/ Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/ Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/ HIV	<input type="checkbox"/>	<input type="checkbox"/>

Have you had any health problems that are not listed?  No  Yes: \_\_\_\_\_

**Authorization and Release**

I certify that the above information is complete and accurate. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the record of any treatment or examination rendered to me or my dependents during the period of such dental care to health practitioners.

\_\_\_\_\_  
Signature of Patient (or Parent/Guardian if minor)      \_\_\_/\_\_\_/\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature of Dentist      \_\_\_/\_\_\_/\_\_\_  
Date

Dr. Notes: \_\_\_\_\_  
\_\_\_\_\_