



Enter your responses from your computer and print this page. Bring it to your appointment or mail/fax it to Dr. Civils.

Patient History Form

Patient Name _____ Phone _____ Cell _____
 Email Address _____
 Street Address _____ Age ____ Birthdate ___ / ___ / ___
 City _____ State _____ Zip _____ SSN ____ - ____ - ____
 Place of Employment _____ Phone _____ Ext. _____
 Address _____ Gender..... M F
 City _____ State _____ Zip _____
 Person responsible for payment _____
 Spouse name in full _____ SSN ____ - ____ - ____
 Spouse Birthdate ____ / ____ / ____
 Spouse employed by _____ Phone _____ Ext. _____
 Address _____ City _____ State _____

If Patient is a Child

Parent/Guardian name in full _____
 Father's Place of Employment _____ Phone _____ Ext. _____
 Address _____ City _____ State _____
 Mother's Place of Employment _____ Phone _____ Ext. _____
 Address _____ City _____ State _____

Whom may we thank for referring you? _____
 Who is your medical doctor? _____
 Previous dentist _____ City/State _____
 When was your last dental appointment (approximate month/year) _____

Dental Insurance Information

Primary

Employer _____
 Name of Policy Holder _____

 Subscriber ID# _____
 Policy Holder DOB ____ / ____ / ____
 Group # _____
 Insurance Co. _____

Secondary

Employer _____
 Name of Policy Holder _____

 Subscriber ID# _____
 Policy Holder DOB ____ / ____ / ____
 Group # _____
 Insurance Co. _____

DENTAL HISTORY

- 1. Are you experiencing pain from your mouth at this time?..... Yes No
If so, explain _____
- 2. Do your gums bleed when you brush? Yes No
- 3. Have you noticed any loose teeth? Yes No
- 4. Shifting teeth? Yes No
- 5. Have you noticed any mouth odors or bad taste? Yes No
- 6. Are your teeth sensitive to heat, cold or sweets? Yes No
- 7. Does food get caught between your teeth? Yes No
- 8. Have you been treated by a periodontist or oral surgeon? Yes No
Name _____ Date _____
- 9. Do you use tobacco products? What and how often? _____ Yes No
- 10. Are you aware of grinding your teeth at night in your sleep? Yes No
- 11. Do you have joint pain in your jaw? Yes No
- 12. Have you ever had an unfavorable dental experience? Yes No
- 13. Did your parents have good teeth? Yes No
- 14. Do you brush and floss your teeth? How often? _____ Yes No
- 15. Are you dissatisfied with the appearance of your teeth? Yes No
- 16. Have we treated any family members? Who? _____ Yes No

MEDICAL HISTORY

- 17. Is your general health good? Yes No
- 18. Has your general health changed within the past year? Yes No
If so, how? _____
- 19. Are you being treated by a physician at this time? Yes No
If so, for what? _____
- 20. Have you ever had major surgery or been hospitalized for an extended period of time? Yes No
What? _____ Complications? _____
- 21. Are you taking any medications regularly? (List name and amount below) Yes No

22. Check all that apply:

- Blood disease/anemia
- Diabetes
- Heart Disease/Heart Attack
- Rheumatic Fever
- Heart Murmur
- Mitral Valve Prolapse
- Bleeding or Clotting Problems
- Bladder, kidney or bowel trouble
- Asthma
- Hepatitis
- Lung Disease
- Joint Replacement
- HIV/AIDS
- Herpes
- Malignancy
- Thyroid or Gland Disease
- Epilepsy/Seizures
- Fainting
- Stroke
- High or low blood pressure
- Angina
- Tuberculosis
- Immune System Disorder
- Other _____

23. Have you ever reacted adversely to:
list the type of reaction

- Penicillin _____
- Aspirin _____
- Codeine _____
- Novocaine _____
- Demerol _____
- Antihistamines _____
- Barbiturates _____
- Anesthetics _____
- Darvon _____
- Antibiotics _____
- Sulfa _____
- Latex _____
- Other _____

- 24. **WOMEN:** Are you pregnant? Yes No
- 25. Do you have any pending medical or dental treatment that may affect your dental care? Yes No
- 26. What was the date of your last medical appointment? _____
What was the appointment for? _____

I understand that I am responsible for any fees for professional services that are rendered.

Signature of Patient/Responsible Party

Date