CIVILS
Doctors of General and Cosmetic Dentistry

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._____

Please complete page 2

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

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