



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:

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