PATIENT INFORMATON

LYNN ALAN PALMER, D.D.S.

PATIENT'S NAME	NAME SPOUSE / PARENT	NAME PARENT / GUARDIAN
DATE OF BIRTH	DATE OF BIRTH	DATE OF BIRTH
SOCIAL SECURITY #	SOCIAL SECURITY #	SOCIAL SECURITY #
DRIVERS LICENSE #	DRIVERS LICENSE #	DRIVERS LICENSE #
ADDRESS	ADDRESS	ADDRESS
CITY	CITY	CITY
STATE / ZIP	STATE / ZIP	STATE / ZIP
HOME PHONE	HOME PHONE	HOME PHONE
CELL PHONE	CELL PHONE	CELL PHONE
E-MAIL	E-MAIL	E-MAIL
EMPLOYER / SCHOOL	EMPLOYER / SCHOOL	EMPLOYER / SCHOOL
ADDRESS	ADDRESS	ADDRESS
CITY & ZIP CODE	CITY & ZIP CODE	CITY & ZIP CODE
WORK PHONE	WORK PHONE	WORK PHONE
OCCUPATION	OCCUPATION	OCCUPATION
LENGTH OF CURRENT EMPLOYMENT	LENGTH OF CURRENT EMPLOYMENT	LENGTH OF CURRENT EMPLOYMENT

* HOW DID YOU HEAR ABOUT OUR OFFICE ?

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE CO NAME	SECONDARY INSURANCE CO NAME
POLICY HOLDER NAME	POLICY HOLDER NAME
INSURANCE CO ADDRESS	INSURANCE CO ADDRESS
INSURANCE CO PHONE	INSURANCE CO PHONE
GROUP # EMPLOYEE ID #	GROUP # EMPLOYEE ID #

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

NAME	RELATIONSHIP	HOME PHONE	WORK PHONE

WHAT ARE YOUR DENTAL NEEDS AT THIS TIME ?

WHAT IS YOUR REASON FOR SEEKING DENTAL TREATMENT?
APPROXIMATE DATE OF LAST DENTAL EXAM:
APPROXIMATE DATE OF LAST DENTAL X-RAYS AND TYPE : FULL SERIES (18) BITEWINGS (4) PANORAMIC
NAME OF LAST TREATING DENTIST:
APPROXIMATE DATE OF ANY DENTAL SPECIALIST TREATMENT:
NAME OF LAST SPECIALIST DENTIST:
HAVE YOU EVER HAD ANY COMPLICATIONS FROM PAST DENTAL TREATMENT?:

HAVE YOU NOTICED ANY OF THE FOLLOWING ?

BLEEDING GUMS DURING TOOTHBRUSHING yes no	PUS BETWEEN THE TEETH AND GUMS yes no
RED, SWOLLEN OR TENDER GUMS yes no	LOOSE OR SEPARATING TEETH yes no
GUMS THAT HAVE PULLED AWAY FROM TEETH yes no	CHANGE IN THE WAY YOUR TEETH FIT TOGETHER yes no
PERSISTENT BAD BREATH OR UNUSUAL MOUTH ODORS yes no	FOOD CATCHING BETWEEN YOUR TEETH yes no
BLISTERS, LESIONS, OR SORE SPOTS IN MOUTH yes no	TMJ OR JAW SYMPTOMS yes no
HAS ANYONE IN YOUR FAMILY HAD OR BEEN TREATED FOR GUM PROBLEMS? yes no	
IS IT IMPORTANT TO YOU TO KEEP YOUR TEETH AS LONG AS POSSIBLE? yes no	
IS THERE ANY PARTICULAR REASON WHY MISSING TEETH HAVE NOT BEEN REPLACED?	
DO YOU LIKE THE APPEARANCE OF YOUR SMILE? yes no	
DO YOU LIKE THE COLOR OF YOUR TEETH? yes no	
DO YOUR TEETH KEEP YOU FROM EATING ANY SPECIFIC FOOD? yes no IF SO, WHAT FOOD?	

HEALTH AND MEDICAL HISTORY OF:

NAME OF PRIMARY CARE PHYSICIAN:	NAME OF SPECIALIST PHYSICIAN(S):
DATE OF LAST EXAM:	ADDRESS:
ADDRESS:	PHONE NUMBER:
PHONE NUMBER:	FOR WHAT TREATMENT(S):
WHAT IS YOUR PHYSICAL STATE OF HEALTH?	DATE OF LAST VISIT TO SPECIALIST:

HAVE YOU EVER HAD OR SUSPECTED?	YES	NO
HEART TROUBLE		
BEEN DIAGNOSED WITH A HEART MURMUR		
AN ARTIFICIAL (PROSTHETIC) HEART VALVE		
A HISTORY OF PREVIOUS ENDOCARDITIS		
VALVE DEFECTS / VALVES DAMAGED (SCARRED) BY CONDITIONS SUCH AS RHEUMATIC FEVER		
MITRAL VALVE PROLAPSE or REGURGITATION		
HYPERTROPHIC CARDIOMYOPATHY		
VENTRICULAR SEPTAL DEFECT		
ATRIAL SEPTAL DEFECT		
PACEMAKER		
BACTERIAL ENDOCARDITIS		
SYSTEMIC PULMONARY SHUNT		
VASCULAR SURGERY LESS THAN 7 MONTHS AGO		
CONGENITAL HEART DEFECT		
ACQUIRED VALVULAR DYSFUNCTION		
PATENT DUCTUS ARTERIOSUS		
ARTIFICIAL JOINTS (SUCH AS HIP, KNEE, ETC.)		
CHRONIC KIDNEY DISEASE		
RENAL DISEASE WITH HEMODIALYSIS		
ABNORMAL BLOOD PRESSURE		
CHEST PAIN		
SHORTNESS OF BREATH; ASTHMA		
HAY FEVER OR OTHER ALLERGIES		
USE(D) TOBACCO IN ANY FORM? FOR HOW LONG?		
ARTHRITIS		
SINUS TROUBLE OR PERSISTENT COUGH		
TUBERCULOSIS		
RHEUMATIC FEVER		
DIABETES OR FREQUENT THIRST		
IF SO, HOW IS YOUR DIABETES CONTROL? (circle one) GOOD FAIR POOR		
ARE YOU PRONE TO DIABETIC COMPLICATIONS?		
OSTEOPOROSIS OR OSTEOPENIA		
EPILEPSY		
KIDNEY OR BLADDER TROUBLE		
BLOOD DISEASE		
HEPATITIS : A B C D E F G (circle all that apply)		
JAUNDICE OR LIVER DISEASE		
AUTOIMMUNE DISEASE		
PROLONGED BLEEDING OR HEMOPHILIA		
SEVERE HEADACHES		
CANCER		
CHEMOTHERAPY, RADIATION TREATMENT		
DIFFICULTY WITH PAST DENTAL TREATMENT		
FAINTING TENDENCY		
YOUR TONSILS REMOVED		
DRY MOUTH SYNDROME OR XEROSTOMIA		
DO YOU HAVE COLD SORES MORE THAN TWICE/YR		
HIV POSITIVE TEST OR AIDS		
OPERATIONS OR SERIOUS ILLNESS(ES) Describe:		
GASTRIC ULCERS ( ) HAVE NOW ( ) HAVE HAD IN THE PAST		
OTHER MEDICAL TREATMENT ? DESCRIBE:		

LIST CURRENT MEDICATIONS (use other side if necessary)

ARE YOU TAKING		THE FOLLOWING DRUGS	HAVE YOU TAKEN	
YES	NO		YES	NO
		ANTI-REJECTION DRUGS		
		CORTISONE / STEROIDS / ACTH		
		ANTICOAGULANTS / BLOOD THINNERS		
		TRANQUILIZERS / SEDATIVES		
		AZT / AZIDOTHYMIDINE		
		ZOVIRAX / ACYCLOVIR / VALTREX / DENAVIR		
		INTRAVENOUS OR ORAL BISPHOSPHONATES		
		COMPOUND S		
		FEN-PHEN / MERIDIA / SIBUTRAMINE		
		AMPHETAMINES / COCAINE		
		RECREATIONAL DRUGS OR HERBS		
		SELDANE		
		RETROVIR / TRIZIVIR / EPIVIR / ZIAGEN		
		VIDEX / VIDEX EC / HIVID / ZERIT		
		VIRAMUNE / RESCRIPTOR / SUSTIVA		
		INVIRASE / FORTOVASE / CRIXIVAN		
		VIRACEPT / AGENERASE / KALETRA		
		TENOFOVIR DISOPROXIL FUMURATE (DF)		
		ACCUTANE OR OTHER ACNE MEDICATION		
		DILANTIN ANTI-SEIZURE MEDICATION		
		CYCLOSPORIN IMMUNOSUPPRESANT THERAPY		
		CALCIUM CHANNEL BLOCKER BLOOD PRESSURE MEDICINE SUCH AS PROCARDIA,CARDIZEM,NORVASC,VERAPAMIL,ETC		
		STREET DRUGS		
		ACTONEL, AREDIA, BONIVA, CALCITONIN,		
		EVISTA, FORTEO, FOSAMAX, ZOMETA		

ALLERGIES	YES	NO
ARE YOU ALLERGIC TO PENICILLIN?		
ARE YOU ALLERGIC OR SENSITIVE TO ANY MEDICATIONS? *List Here:*		
ARE YOU ALLERGIC OR SENSITIVE TO ANY METALS? *List Here:*		
HAVE YOU EVER HAD A PROBLEM WITH NOVOCAINE OR WITH A SIMILAR ANESTHETIC? *Describe:*		
HAVE YOU EVER HAD ANY UNDESIRABLE EFFECTS WITH AN ANESTHETIC? *Describe:*		
ARE YOU ALLERGIC OR SENSITIVE TO LATEX OR RUBBER?		

FOR FEMALE PATIENTS ONLY	YES	NO
ARE YOU PREGNANT ?		
ARE YOU NURSING ?		
ARE YOU TAKING BIRTH CONTROL MEDICINE?		
ARE YOU TAKING HORMONE SUPPLEMENTS?		
DO YOU HAVE OR ARE YOU AT RISK FOR OSTEOPOROSIS?		
ARE YOU TAKING MEDICATION FOR OSTEOPOROSIS SUCH AS: ACTONEL, BONIVA, CALCITONIN, EVISTA, FORTEO, FOSAMAX OR OTHERS?		
HAVE YOU HAD A MASTECTOMY? LEFT ( ) RIGHT ( )		

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered.

I have read all the information on both sides of this sheet and have completed the answers. I certifity this information is true and correct to the best of my knowledge.

SIGNATURE OF PATIENT / GUARDIAN	PERSON WHO FILLED OUT THIS FORM & RELATIONSHIP TO PATIENT:
X DATE:	NAME: RELATIONSHIP: