

PATIENT INFORMATION

DATE _____

Name _____
Last First Middle Nickname
Address _____ Apt # _____
City _____ State _____ Zip code _____
Home Phone() _____ Work Phone() _____ Ext _____
Cell Phone() _____ Pager() _____

☐ Married ☐ Single ☐ Child ☐ Other
Birthday / /
Driver's License # _____ State _____
Social Security # _____
E-mail _____

Employer _____
Occupation _____
Business Address _____
City _____ State _____ Zip code _____

In case of an emergency, please contact:
Name _____ Relationship _____
Phone _____ Cell phone _____
Nearest relative not living with you _____
Relationship to patient _____ Phone _____

Whom may we thank for referring you? _____

Is another member of your family a patient at our office? ☐ Yes ☐ No Their name? _____

Method of payment: ☐ Cash ☐ Check ☐ VISA/MC/Discover

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT ☐ Patient ☐ Parent ☐ Guardian

Name _____
Last First Middle Nickname
Address _____ Apt # _____
City _____ State _____ Zip code _____
Home Phone () _____ Work Phone() _____ Ext _____
Cell phone/pager _____ E-mail _____
How long at present address? _____

Social Security # _____
Driver's License # _____ State _____
Birthday / /
Employer _____
Occupation _____
Business Address _____
City _____ State _____ Zip _____

DENTAL HISTORY

1. Are you presently in pain? ☐ YES ☐ NO
☐ Teeth ☐ Jaw ☐ Gums ☐ Face ☐ Other
2. Have you had any teeth removed? ☐ YES ☐ NO
If the teeth were replaced, how? _____
3. Is any part of your mouth sensitive to the following? ☐ YES ☐ NO
☐ Hot ☐ Cold ☐ Pressure ☐ Sweet ☐ Sour ☐ Other
4. Have you ever had periodontal treatment or gum surgery? ☐ YES ☐ NO
If YES, when? _____ By whom? _____
5. Please check known conditions:
☐ Bleeding gums when brushing ☐ A burning sensation in your mouth ☐ Grind/clench at night
☐ Food catches between your teeth ☐ Bad taste or odor in your mouth ☐ Jaw clicking or popping
☐ Feel anxious about dental treatment ☐ Unusual dryness in your mouth ☐ Tired, stiff, or painful jaw muscles
6. Are you aware of any growths or swellings in your mouth? ☐ YES ☐ NO
If YES, where are they located and how long have they existed? _____
7. Are you dissatisfied with the appearance of your teeth? ☐ YES ☐ NO
If YES, what would you most like to change? _____
8. Are you interested in learning how to control dental disease to preserve your teeth & oral health? ☐ YES ☐ NO
9. Have you had any unpleasant dental experiences? Do you have concerns we need to be aware of? ☐ YES ☐ NO
If yes, explain: _____

HEALTH HISTORY

Please complete the following confidential information. Your complete answers will assist us in treating you with consideration for your special needs.

- Family Physician _____ Date of last visit _____ Reason for this visit _____
1. Do you have a current medical problem or condition? Condition: _____ ☐ YES ☐ NO
If yes, physician's name: _____ Phone: _____
2. Have you been hospitalized or have you had a serious illness within the last 5 years? ☐ YES ☐ NO
If so, list illness or operations/dates: _____
3. Do you have heart trouble or any form of cardiovascular disease (Please (✓) check known conditions)? ☐ YES ☐ NO
- | | | |
|--|---|--|
| ☐ Heart surgery (Date _____) | ☐ Angina/chest pains (Frequency _____) | ☐ High blood pressure |
| ☐ Prosthetic heart valve (Date _____) | ☐ Heart attack (Date _____) | ☐ Stroke (Date _____) |
| ☐ Bypass (Date _____) | ☐ Heart murmur | ☐ Low blood pressure |
| ☐ Angioplasty (Date _____) | ☐ Mitral valve defect | ☐ Atherosclerosis |
| ☐ Pacemaker (Date _____) | ☐ Congenital heart defect | ☐ Other _____ |
4. Please list any medications and dosages you currently take or have taken in the last year: _____
5. Are you under any unusual stress at home or at work? If yes, explain: _____
6. Do you or have you ever had any of the following (please (✓) check all known conditions)? ☐ YES ☐ NO
- | | | |
|--|--|---|
| ☐ Tuberculosis (Date _____) | ☐ Epilepsy or seizures | ☐ Hepatitis (Date _____ Type _____) |
| ☐ Liver disease or jaundice | ☐ Persistent cough | ☐ Fainting or dizzy spells |
| ☐ Kidney disease | ☐ Emphysema/Asthma | ☐ Arthritis |
| ☐ Diabetes (Type I or II) | ☐ Sinus trouble/Hay fever | ☐ Chronic head, neck or back pain |
| ☐ Hypo/Hyperglycemia | ☐ Allergies or hives _____ | ☐ Artificial joint, limb, or implant (hip, knee) |
| ☐ Glaucoma | ☐ HIV | ☐ Nervousness |
| ☐ Hypo/Hyperthyroidism | ☐ AIDS or ARC | ☐ Psychiatric treatment |
| ☐ Stomach or intestinal ulcers | ☐ Herpes | ☐ Alcoholism |
| ☐ Prolonged bleeding | ☐ Drug Addiction | ☐ Venereal Disease (Syphilis, Gonorrhea) |
| ☐ Anemia | ☐ Cancer _____ | ☐ Special diet |
| ☐ Sickle cell disease | ☐ Chemotherapy (Date _____) | ☐ Cosmetic Surgery (face, neck) |
| ☐ Blood transfusion | ☐ Cortisone medicine | ☐ Wearing contact lenses |
| ☐ Bruise easily | ☐ Limitation of activity | ☐ Other _____ |
| ☐ Smoking history- (cigarettes, e-cigarettes, smokeless tobacco (dipping), hooka,, vaping & recreational drugs.
age: _____ Packs/day: _____ other usage: _____ | | |
7. Have you ever taken prophylactic antibiotics prior to dental treatment? ☐ YES ☐ NO
8. Are you allergic to or have you had any unusual reaction to any drugs or medicines? ☐ YES ☐ NO
If yes, please list: _____
9. Are you allergic to or have you ever reacted adversely to latex? ☐ YES ☐ NO
10. Have you had surgery, radiation or other treatments for a tumor or growth to head or neck? ☐ YES ☐ NO
11. For women only: Are you pregnant? If so what month? _____ ☐ YES ☐ NO
Are you taking birth control pills? _____ ☐ YES ☐ NO

I understand the responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time of service. The above medical information is correct to the best of my knowledge. If I have any change in my health or medications, I will inform the doctor at my next appointment. I hereby authorize the release of any medical information to an insurance company I claim benefits with and assign those benefits to Thomas H. Pitts, D.M.D. In addition, I hereby grant permission for the release of any medical information to any physician, if deemed necessary for my dental care. I authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation, and give consent for dental treatment to be performed by Dr. Pitts and his staff. I understand the use of anesthetic agents embodies a certain risk. I consent to receive phone calls or text messages regarding my treatment with Dr. Pitts.

Patient Signature _____ Date _____
Parent/Financially Responsible Person _____ Relationship _____