Patient Information Form

Directions: You are the patient. At home, fill out this form with your information. You do not need to share this with your instructor or the class.

1. Last name: _____

   First name: _____ Middle initial: _____

2. Street address: _____

   City: _____ State: _____

   Zip code: _____

3. Date of birth: _____
   (month, day, year)

4. Social Security Number: _____

5. Marital status -- put a check mark (√) on the correct blank:

   Single ____ Married ____ Divorced ____ Widowed ____

6. Occupation/job: _____

7. Employer's name: _____

8. Employer's street address: _____

   City: _____ State: _____

   Zip code: _____

Patient Information Form, continued

9. Last name of spouse: _____

   First name: _____ Middle initial: _____

10. Spouse's Social Security Number: _____

11. Insurance provider name: _____

12. Name of holder of this insurance plan: _____

13. Relationship to patient: _____

14. Insurance Group # _____ ID #: _____

15. Emergency phone number: _____

16. Name of emergency contact: _____

17. Relationship to patient: _____

Patient Medical History Form

Directions: You are the patient. At home, fill out this form with your information. You do not need to share this with your instructor or the class.

1. Date of last medical exam (month, year) _____

2. Have you ever been hospitalized for surgery or serious illness? Yes ___ No ___
If yes,

Date	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Are you taking any medications (prescriptions or over-the-counter) regularly?

Yes _____ No _____ If yes, what medications are you taking?

_____

_____

_____

_____

4. Do you wear glasses or contact lenses? Yes _____ No _____

Patient Medical History Form, continued

5. Are you allergic to any medication or have you had any reactions?

Yes _____ No _____ If yes, fill out the chart below.

Name of Medication	Reaction	When

6. Are you allergic to anything else (food, pollen, dust, etc.)? Yes ____ No _____

7. Do you have or have you had any of the following:

a. arthritis Yes _____ No _____
b. diabetes Yes _____ No _____
c. hypertension/high blood pressure Yes _____ No _____
. d. high cholesterol Yes _____ No _____
e. mental illness Yes _____ No _____
f. kidney disease Yes _____ No _____
g. osteoporosis Yes _____ No _____
h. sexual/physical abuse Yes _____ No _____
i. thyroid disease Yes _____ No _____
j. HIV/AIDS Yes _____ No _____
k. heart disease/heart attack Yes _____ No _____
l. substance abuse Yes _____ No _____
m. alcoholism Yes _____ No _____
n. asthma Yes _____ No _____
o. seizures Yes _____ No _____

p.	stroke	Yes _____	No _____
q.	anemia/blood diseases	Yes _____	No _____
r.	liver diseases	Yes _____	No _____
s.	immune problems	Yes _____	No _____
t.	cancer	Yes _____	No _____
u.	frequently tired	Yes _____	No _____
v.	recent weight loss	Yes _____	No _____
w.	other:		

_____

_____

8. For Women Only

pregnancies _____ # live births _____

Date of last Pap Smear _____ Date of last Mammogram _____

Age periods began _____ First day of last period _____

Do you use birth control? Yes _____ No _____

If yes, what kind? _____

Patient Dental Form

Directions: You are the patient. At home, fill out this form with your information. You do not need to share this with your instructor or the class.

1. Do your gums bleed while brushing or flossing? Yes ___ No ___

2. Are your teeth sensitive to hot or cold liquids/foods? Yes ___ No ___

3. Are your teeth sensitive to sweet or sour liquids/foods? Yes ___ No ___

4. Do you feel pain in any of your teeth? Yes ___ No ___

5. Do you have any sores or lumps in or near your mouth? Yes ___ No ___

6. Have you had any head, neck or jaw injuries? Yes ___ No ___

7. Have you ever experienced any of the following problems in your jaw:

    a. Clicking? Yes ___ No ___

    b. Pain (joint, ear, side of face)? Yes ___ No ___

    c. Difficulty in opening or closing? Yes ___ No ___

    d. Difficulty in chewing? Yes ___ No ___

8. Do you have headaches often? Yes ___ No ___

9. Do you clench or grind your teeth? Yes ___ No ___

10. Do you bite your lips or cheeks often? Yes ___ No ___

Patient Dental Form, continued

11.	Have you ever had any difficult extractions in the past?	Yes ___ No ___
12.	Have you had any orthodontic treatment?	Yes ___ No ___
13.	Have you ever had prolonged bleeding following extractions?	Yes ___ No ___
14.	Have you ever had instruction on the correct method of brushing your teeth?	Yes ___ No ___
15.	Have you ever had instructions on the care of your gums?	Yes ___ No ___

Patient Family History Form

Directions: You are the patient. At home, fill out this form with your personal information. You do not need to share this with your instructor or the class.

Has anyone in your family ever had any of the following?

	Yes	No	If yes, who? (e.g., father, mother, sibling, son, daughter, grandparent, etc.)
arthritis			
diabetes			
hypertension/ high blood pressure			
high cholesterol			
mental illness			
kidney disease			
osteoporosis			
sexual/physical abuse			
thyroid disease			
HIV/AIDS			
heart disease/ heart attack			
substance abuse			

Patient Family History Form, continued

	Yes	No	If yes, who? (e.g., father, mother, sibling, son, daughter, grandparent, etc.)
alcoholism			
asthma			
seizures			
stroke			
anemia/blood disease			
liver diseases			
immune problems			
cancer - fill in the blank for type: _____ _____ _____			
other disease - fill in the blank: _____ _____ _____			