

Charles W. Cline, D.D.S.
Family Dentistry

Patient Information

Date: ___/___/___

Patient's Name: _____
Last First M.I.

Home Address: _____
Street City / State Zip

Office Phone: _____ Home Phone: _____ Cell: _____

Email Address: _____ DL#: _____

Date of Birth: ___/___/___ Social Security #: ___/___/___

Height: _____ Weight: _____ Marital Status: S M W D Sex: M ___ F ___

Name of patient's physician: _____ Physician's Phone: _____
Date Last Seen: _____ Address: _____
WHOM SHOULD WE THANK FOR REFERRING YOU TO US? _____

In Case of Emergency: Nearest relative (not living at your address):
Name: _____ **Address:** _____
Relationship: _____ **Street** **City/State** **Zip**
Home Phone: _____ **Work Phone:** _____ **Cell:** _____

If Applicable: Spouse's Name: _____ **SS#:** _____
Date of Birth: ___/___/___ Employer: _____ Occupation: _____

IF PATIENT IS A MINOR:
Father's Name: _____ **Work Phone:** _____ **Cell:** _____
Home Address (If different): _____ **Home Phone:** _____
Name of Employer: _____ **SS#:** _____ **Date of Birth:** ___/___/___
Email Address: _____ **DL #:** _____ **State:** _____
Mother's Name: _____ **Work Phone:** _____ **Cell:** _____
Home Address (If different): _____ **Home Phone:** _____
Name of Employer: _____ **SS#:** _____ **Date of Birth:** ___/___/___
Email Address: _____ **DL #:** _____ **State:** _____

Is the patient covered by Dental insurance? Yes ___ or No ___ Insured SS#: _____
Group #: _____ Insurance ID #: _____ Insurance Company: _____
Name of Insured Employee: _____ Insured's Employer: _____
Insured Date of Birth: ___/___/___ Insured Employers Phone #: _____
If patient is over 19 years of age and covered on parent's policy, are they a full time student? Yes ___ No ___

ASSIGNMENT OF INSURANCE BENEFITS: In consideration of services rendered, I hereby transfer and assign to CHARLES W. CLINE, D.D.S. all right and title and interest in any payment due me for services as provided in the policy or policies of insurance held by me or on my behalf. I agree TO PAY DR. CHARLES W. CLINE, D.D.S. the charges which exceed the amount paid by the policies held by me. I further agree and authorize the above named clinic to release any information requested by the insurance company (is) or it's representatives. I understand that I will be held responsible for any fees that are not paid by the insurance company.

POLICY HOLDER SIGNATURE Date Witness Date

Charles W. Cline, D.D.S.
Family Dentistry

Medical History

Date: ___/___/___

Patient Name: _____

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. All information will be kept confidential.

****PLEASE ANSWER BY CHECKING YES (Y) OR NO (N) FOR EACH INDIVIDUAL QUESTION ****

Yes ___ No ___ 1. How would you describe your general health? Poor _____ Fair _____ Good _____

Yes ___ No ___ 2. Has there been any change in your general health within the past year?

If yes, please explain: _____

Yes ___ No ___ 3. Are you currently under a physician's care?

If yes, what for? _____

Physician's name: _____ Phone #: _____

Yes ___ No ___ 4. Date of your last checkup by a physician: ___/___/___

Yes ___ No ___ 5. Have you had any serious illness, operations, or hospitalizations?

If yes, what for? _____

Approximate Dates: _____

Yes ___ No ___ 6. Have you ever had intravenous sedation or general anesthesia?

Were there any adverse effects? _____

Yes ___ No ___ 7. Do you generally tolerate dental treatment well?

8. DO YOU HAVE OR HAVE YOU EVER HAD:

Yes ___ No ___ A. Heart Disease that was detected at birth? (valve damage, murmur, artificial heart valve)?

Yes ___ No ___ B. Have you ever been pre-medicated with antibiotics for dental treatment?

Yes ___ No ___ C. Rheumatic Fever or Rheumatic heart disease?

Yes ___ No ___ D. Cardiovascular disease (chest pain, heart trouble, heart attack, coronary artery disease, high blood pressure, stroke, palpitations, heart surgery, angioplasty, pacemaker)?

Yes ___ No ___ E. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath)?

Yes ___ No ___ F. Neurologic disorders (seizure, epilepsy, fainting, dizziness, nervous disorder)?

Yes ___ No ___ G. Blood disease (bleeding disorder, anemia, blood transfusion, do you bruise easily)?

Yes ___ No ___ H. Liver disease (jaundice, hepatitis)?

Yes ___ No ___ I. Kidney disease?

Yes ___ No ___ J. Thyroid disease (hypothyroidism, tumor)?

Yes ___ No ___ K. Diabetes? If yes Type I _____ or Type II _____ ?

Yes ___ No ___ L. Stomach ulcers or Intestinal problems?

Yes ___ No ___ M. Glaucoma?

Yes ___ No ___ N. Frequent or recurring mouth sores?

Yes ___ No ___ O. Arthritis? (Which joints?)

Yes ___ No ___ P. Implants/artificial joints anywhere in your body? (heart valve, hip, knee)?

Yes ___ No ___ Q. Have you ever been diagnosed with cancer?

1. Have you received chemotherapy? If yes last treatment? _____

2. Have you received radiation therapy? If yes last treatment? _____

Yes ___ No ___ R. Sinus or nasal problems?

Yes ___ No ___ S. Any disease, drug or transplant operation that has depressed your immune system?

Yes ___ No ___ T. Recurrent infections of any kind?

9. ARE YOU TAKING OR USING ANY OF THE FOLLOWING:

Yes ___ No ___ A. Antibiotics?

Yes ___ No ___ B. Anticoagulants (blood thinners)?

Yes ___ No ___ C. Thyroid Medication?

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Medical History (Continued)

- Yes ___ No ___ D. High blood pressure or heart medications?
Yes ___ No ___ E. Steroids?
Yes ___ No ___ F. Tranquilizers, Antidepressants?
Yes ___ No ___ G. Stomach or GI medications (antacids, etc.)?
Yes ___ No ___ H. Cholesterol reducing drugs?
Yes ___ No ___ I. Aspirin, ibuprofen, NSAIDS or anti-inflammatory drugs, narcotics, opioids, or other pain relievers?
Yes ___ No ___ J. Weight reduction pills or diet aids. (over the counter or "natural products")?
Yes ___ No ___ K. Vitamins, Natural remedies (gingko biloba, ephedra, ginseng, etc.)?
Yes ___ No ___ L. Marijuana, cocaine or other "recreational" drugs?
Yes ___ No ___ M. Any other regular medications, pills, supplements or drugs?

PLEASE LIST ALL CURRENT MEDICATIONS HERE: _____

10. ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM:

- Yes ___ No ___ A. Local anesthetic (Novocain-like drugs)?
Yes ___ No ___ B. Penicillin, Amoxicillin, Cephalosporins?
Yes ___ No ___ C. Other antibiotics?
Yes ___ No ___ D. Barbiturates, sedatives?
Yes ___ No ___ E. Aspirin, ibuprofen, NSAIDS, or other pain medicines?
Yes ___ No ___ F. Codeine or narcotics or opioids?
Yes ___ No ___ G. Latex?
Yes ___ No ___ H. Other allergies or reactions?

Please list: _____

- Yes ___ No ___ 11. Do you have hay fever, frequent skin rashes, etc...?
Yes ___ No ___ 12. Do you use alcohol? If so, how much per day? _____
Yes ___ No ___ 13. Do you smoke? If yes, how much per day? _____ For how long? _____
Yes ___ No ___ 14. Do you use spit or chewing tobacco? If yes, for how long? _____
Yes ___ No ___ 15. Are you, or have you been, in a drug or alcohol recovery program?
Yes ___ No ___ 16. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? _____
Yes ___ No ___ 17. Do you wish to talk to the doctor privately about anything?
Yes ___ No ___ 18. Any additional comments? _____

19. WOMEN

- Yes ___ No ___ A. Are you taking birth control pills?
Yes ___ No ___ B. Are you pregnant, trying to become pregnant or is there, **any chance you might be pregnant?**
Yes ___ No ___ C. Are you breast feeding?
Yes ___ No ___ D. Are you taking hormonal replacement?

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY AND REALIZE THAT INCOMPLETE INFORMATION MAY HAVE AN ADVERSE EFFECT ON MY TREATMENT. TO THE BEST OF MY KNOWLEDGE, THE INFORMATION ABOVE IS COMPLETE AND ACCURATE.

Signature of Person Completing Health History

____/____/____
Date

Doctor's Initials

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Dental History

Date: ___/___/___

Patient Name: _____

1. What is your chief dental problem? _____

Yes ___ No ___ 2. Have you ever had a local anesthetic ("Novocain") for dental purposes?

Yes ___ No ___ 3. Have you ever had any reactions to a dental injection?

Yes ___ No ___ 4. Have you had any difficulty with any dental treatment in the past?

Yes ___ No ___ 5. Have you had any prolonged bleeding with extractions in the past?

Yes ___ No ___ 6. Do you have any unhealed injuries or sores in or around your mouth?

Yes ___ No ___ 7. Have you been advised on the care of your teeth and gums?

Yes ___ No ___ 8. Do your gums bleed while brushing?

Yes ___ No ___ 9. Do you floss? How often?

Yes ___ No ___ 10. Have you had any head, neck, or facial pain?

Yes ___ No ___ 11. Have you had any head or neck injuries such as whiplash?

Yes ___ No ___ 12. Do you have problems with earaches?

Yes ___ No ___ 13. Do you have problems with headaches?

Yes ___ No ___ 14. Do you habitually clench or grind your teeth during the day or night?

Yes ___ No ___ 15. Do you tend to chew on one side only? If so, which side? Left _____ or Right _____

Yes ___ No ___ 16. Do you have any popping, clicking, or other noises from your jaw joint(s)?

Yes ___ No ___ 17. How long has it been since your last dental visit?

X-Rays? _____ Cleaning? _____

Yes ___ No ___ 18. Have you ever had orthodontics (Braces)? When? _____ For how long? _____

Yes ___ No ___ 19. Have you ever had Periodontal (Gum) Surgery? If so when? _____

Yes ___ No ___ 20. Other major dental treatment? If so, please explain: _____

Yes ___ No ___ 21. Are you unhappy with your smile or any particular aspect of the way your teeth look or feel? If so, please explain: _____

HOW DO YOU FEEL ABOUT LOSING A TOOTH?

_____ **A. Horrible, I want to keep all my teeth?**

_____ **B. Acceptable, it happens?**

_____ **C. Would not concern me?**

I certify that the answers given are correct to the best of my knowledge. Furthermore, I authorize the release of any medical and/or dental information necessary for the completion of my treatment.

Signature of Patient, Parent or Legal Guardian

___/___/___
Date