# PATIENT HISTORY & INFORMATION

## MEDICAL HISTORY

Patient's name _____

Physician's name: _____ City/State: _____ Phone _____

When was your last physical examination? _____ Results: _____

Have you been a patient in a hospital in the past 5 years: ☐ Yes ☐ No Reason: _____

Have you had any serious illness or operations? ☐ Yes ☐ No Type: _____

Do you have, or have you ever had, any of the following (Please check and describe fully under remarks):

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| 1 Heart Disease | ☐ | ☐ | 15. Psychiatric Treatment | ☐ | ☐ | 29. Hepatitis, A or B | ☐ | ☐ |
| 2 High Blood Pressure | ☐ | ☐ | 16. Arthritis | ☐ | ☐ | 30 Chronic Headaches | ☐ | ☐ |
| 3 Blood Disorder — Anemia | ☐ | ☐ | 17. Night Sweats | ☐ | ☐ | 31. Ringing in the Ears | ☐ | ☐ |
| 4 Rheumatic Fever | ☐ | ☐ | 18. Persistent Cough | ☐ | ☐ | 32. Allergies | | |
| 5 Heart Murmur | ☐ | ☐ | 19. Tumor History | ☐ | ☐ | a. Penicillin | ☐ | ☐ |
| 6 Artificial Joints or Devices | ☐ | ☐ | 20. Chemotherapy | ☐ | ☐ | b. Other Antibiotics | ☐ | ☐ |
| 7 Heart Valve Damage or Replacement | ☐ | ☐ | 21. Radiation Treatment | ☐ | ☐ | c. Codeine, Aspirin | ☐ | ☐ |
| 8 Chest Pain | ☐ | ☐ | 22. Immune System Disorders | ☐ | ☐ | d Local Anesthetic, Novocain | ☐ | ☐ |
| 9 Thyroid Disease, Hyperthyroidism | ☐ | ☐ | 23. AIDS, ARC or HIV Infection | ☐ | ☐ | e. Others | ☐ | ☐ |
| 10 Diabetes | ☐ | ☐ | 24. Venereal Disease | ☐ | ☐ | 33. Asthma | ☐ | ☐ |
| 11 Stroke | ☐ | ☐ | 25. Sinus Trouble | ☐ | ☐ | 34. Tuberculosis, Emphysema | ☐ | ☐ |
| 12 Epilepsy or Seizures | ☐ | ☐ | 26. Ulcers | ☐ | ☐ | 35. Do You Smoke? | ☐ | ☐ |
| 13 Fainting | ☐ | ☐ | 27. Liver or Kidney Disease | ☐ | ☐ | 36. Are You Pregnant? | ☐ | ☐ |
| 14 Persistent Swollen Glands | ☐ | ☐ | 28. Jaundice | ☐ | ☐ | 37. Have you taken Fen-Phen or Redux? | ☐ | ☐ |

Have you had excessive bleeding requiring treatment? ☐ Yes ☐ No

Are you taking any medicines, drugs or pills? ☐ Yes ☐ No If yes, what? _____

Do you have any disease, condition or problem not listed above? _____

_____

_____

## DENTAL HISTORY

| | | |
|---|---|---|
| 1 Are you satisfied with the appearance of your teeth and smile? | ☐ Yes | ☐ No |
| 2. Do your gums bleed when you brush? | ☐ Yes | ☐ No |
| 3. Do you feel that you can chew properly and without pain? | ☐ Yes | ☐ No |
| 4. Have you had orthodontic treatment? | ☐ Yes | ☐ No |
| 5. Have you ever had gum surgery? | ☐ Yes | ☐ No |
| 6. Have you had dental implants placed? | ☐ Yes | ☐ No |
| 7 Have you been told that you snore? | ☐ Yes | ☐ No |
| 8. Do you have a problem with bad breath? | ☐ Yes | ☐ No |
| 9. Are you aware of grinding your teeth? | ☐ Yes | ☐ No |
| 10. Do you feel anxiety about coming to the Dentist? | ☐ Yes | ☐ No |
| 11 Do you require antibiotic premedication prior to dental treatment? | ☐ Yes | ☐ No |
| 12 Have you experienced any unfavorable reactions to previous dental treatment? | ☐ Yes | ☐ No |

13 Name of former dentist: _____ Phone _____ Date of last exam: _____

14. Please note any special dental concerns that bring you to our office: _____

_____

_____

_____

Patient Signature _____ Date _____

Doctor's Signature _____ Date _____

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# Harold Perlaza, D.D.S
## Dental Studio
# PATIENT REGISTRATION

PLEASE PRINT

NAME: M_____ _____
Last First Middle

Birthdate: _____ Sex: _____ Home Phone: _____

Social Security No.: _____ Driver's License No.: _____

Address (Home) _____ Age _____
Street City State/Zip

Employer _____ Occupation _____

Address (Bus) _____ Bus. Phone: _____
Street City State/Zip

INSURANCE COMPANY: _____ Group No.: _____ Certificate No.: _____

Insurance Eligibility Date: _____ Secondary Coverage: _____

NAME OF PERSON POLICY IS CARRIED ON: _____ Relationship: _____ Phone. _____

Address: _____ City/State/Zip _____

Employer: _____ Occupation: _____

Social Security No.: _____ Driver's License No.: _____

NAME OF SPOUSE: _____
Last First Middle

Birthdate: _____ Sex: _____ Home Phone: _____

Address (Bus) _____ Bus. Phone: _____
Street City State/Zip

Social Security No.: _____ Driver's License No. _____

NEAREST RELATIVE IN AREA: _____ Address: _____ Phone: _____

Who can we thank for referring you to this office? _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health or medications I will inform the doctor at the next appointment. I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, and other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by the dentist and office staff, and I will assume financial responsibility.