

St. Louis County Dental Partnership

469 S. Kirkwood Rd. Kirkwood, MO 63122
(Woodbine Center)

PATIENT INFORMATION

NAME _____
LAST FIRST MI TITLE - CIRCLE ONE MR. MRS. MS. DR.

ADDRESS _____
NUMBER & STREET CITY STATE ZIP

SOC. SEC. NUMBER () HOME PHONE () BUSINESS PHONE EXT

M F
SEX DATE OF BIRTH YOUR OCCUPATION EMPLOYER YRS WITH FIRM

()
CELL NUMBER E-MAIL ADDRESS

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY OCCUPATION EMPLOYER YRS WITH FIRM

NAME _____
LAST FIRST MI

ADDRESS _____
NUMBER & STREET CITY STATE ZIP () HOME PHONE

()
AC BUSINESS PHONE SOC. SEC. NUMBER M F
SEX DATE OF BIRTH

DENTAL INSURANCE INFORMATION

EMPLOYER _____
COMPANY NAME ADDRESS - NUMBER & STREET CITY

STATE ZIP () EMPLOYERS PHONE GROUP NUMBER GROUP NAME

INS. COMPANY NAME ADDRESS NUMBER & STREET CITY

STATE ZIP () INSURANCE PHONE NUMBER EXT

ADDITIONAL INFORMATION

SPOUSES OCCUPATION EMPLOYER YRS WITH FIRM

SPOUSE _____
FIRST NAME MI DATE OF BIRTH SOC. SEC. NUMBER () BUSINESS PHONE EXT

IF YOU ARE COMPLETING THIS FORM FOR ANOTHER PERSON, WHAT IS YOUR RELATIONSHIP TO THAT PERSON? _____

PERSON TO CONTACT IN
CASE OF EMERGENCY _____
NAME DAYTIME PHONE EVENING PHONE

I LEARNED OF YOUR
OFFICE BY: ☐ REFERRED BY _____ ☐ PHONE BOOK ☐ OFFICE SIGN ☐ OTHER
NAME PLEASE SPECIFY

I UNDERSTAND THAT PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.
IF I DEFAULT IN PAYMENT AND COLLECTION IS REQUIRED, I WILL BE RESPONSIBLE FOR ALL COLLECTION AND/OR ATTORNEY FEES AND
COURT COSTS. COLLECTION FEES OF 30% WILL BE CHARGED TO ME AND I AGREE AND UNDERSTAND THAT I WILL BE RESPONSIBLE FOR
THOSE FEES.

DATE

SIGNATURE OF PATIENT OR GUARDIAN

Medical History

PATIENT NAME _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No

Physician name and phone # _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No Please List _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No ☐ N/A _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No **Please List** _____

Have you ever taken medication or injections for osteoporosis? ☐ Yes ☐ No **Please List** _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No ☐ N/A Do you use tobacco? ☐ Yes ☐ No ☐ N/A

Are you on a special diet? ☐ Yes ☐ No ☐ N/A Do you use controlled substances? ☐ Yes ☐ No ☐ N/A

Women: Are you ☐ Pregnant / Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

Are you allergic to any of the following? _____

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____

Do you have, or have you had, any of the following? _____

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Snoring/Sleep Apnea |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles | |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease | |

Have you ever had any serious illness not listed above? ☐ Yes ☐ No ☐ N/A _____

Comments: _____

*Condition may require medication N/A - Not answered by patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

REVIEWED BY DOCTOR _____ DATE _____

I understand that I am responsible for any missed appointment fees should I neglect to keep my scheduled appointment without at least 24 hours notice.

SIGNATURE _____

DATE _____

Dental History

Name: _____

Type of Dental Treatment Desired (Check one)

- ☐ Emergency (Relief of pain and treatment of chief complaint only)
- ☐ Complete (Initial examination and treatment as required)
- ☐ Consultation (Please specify) _____
- ☐ Other _____

Date of last dental treatment: _____

Dental services received: _____

Describe chief dental concern: _____

	Please Check: YES	NO
Do you feel discomfort in your teeth when chewing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any places where food packs between teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel discomfort in your jaw or ears when chewing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain, discomfort, sores, or lumps anywhere in your head or neck area?	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when chewing or brushing?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been treated for gum disease?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have unpleasant breath or an unpleasant taste in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Are you confident in your ability to properly clean your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel you chew efficiently?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pleased with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed any darkening of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you lost any teeth?	<input type="checkbox"/>	<input type="checkbox"/>
If so, were they replaced?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel you will eventually lose all of your teeth even with proper care?	<input type="checkbox"/>	<input type="checkbox"/>
Do any members of your family, including your parents, wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>
Are you concerned about the finances required to return your mouth to excellent dental health?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get frustrated because you always have something to be treated or repaired when you visit the dentist?	<input type="checkbox"/>	<input type="checkbox"/>
If, by magic, you could change anything about your teeth, what would you change? _____		

Do you have any interest in cosmetic injectables?	<input type="checkbox"/>	<input type="checkbox"/>