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**

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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? _____
Approximage 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 amt-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 took or feel? If so, please explain: _____
_____
_____
_____

HOW DO YOU FEEL ABOUT LOOSING 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**