GARY L. HARRIS, D.D.S., P.C.

PATIENT INFORMATION

So that we may give you the best care, please complete the patient information, medical history, and dental history.
If you have any questions regarding these forms, we will be glad to help.

Referred by: ____

Patient Name (Mr. Mrs. Miss. Ms. Dr.): ____

Birth Date: ________________ Age: ________ Sex: ______ Marital Status:__________________________________

If Married, Spouse's Name: ____

Address: ____
Number Street City/State Zip Code

Home Phone:_________________________________ Business Phone: ______________________________________

Cell Phone:__________________________________ Email: ____

Social Security Number: ______________________ Driver's License Number: ______________________________

Employer: ___________________________________ Occupation: ____

Person Responsible for Payment (If Other Than Above)

Name:______________________________________ Relationship to Patient: ________________________________

Address: ____
Number Street City/State Zip Code

Home Phone: ________________________________ Business Phone: _____________________________________

Social Security Number: ______________________ Driver's License Number: ______________________________

Employer: ___________________________________ Occupation: ____

Employer's Address: ____
Number Street City/State Zip Code

CONSENT FOR TREATMENT

I Authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I Authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the Contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

Signature: ____________________________________ Date: ____
(Patient/Guardian)

GARY L. HARRIS, D.D.S., P.C.

Medical History

Patient Name: ______________________ Date of last physical: ______________________________

Physicians Name: ____________________ Phone: ______________________________________

1. Are you seeing any specialists? ……………………………………………………… …………………….……Yes No

If yes, specialist's name and reason: ____

2. Have you been a patient in the hospital during the past five years?..Yes No
If yes, for what? ____

____

3. Are you taking any medication, drugs or pills now? ……………………………………………….……………Yes No

If yes, please list name and dosage: ____

____

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? ……………………….………Yes No

If yes, please list: ____

____

5. Indicate which of the following you have had, or have at present.

ق Heart Surgery/Disease/Attack
ق Chest Pain
ق Congenital Heart Disease
ق Heart Murmur
ق High Blood Pressure
ق Mitral Valve Prolapse
ق Artificial Heart Valve
ق Heart Pace Maker
ق Rheumatic Fever
ق Arthritis/Rheumatism
ق Cortisone Medicine
ق Swollen Ankles
ق Stroke
ق Diet (Special/Restricted)
ق Artificial Joints (Hip/Knee/Etc.)
ق Kidney Trouble

ق Ulcers
ق Diabetes
ق Thyroid Problems
ق Glaucoma
ق Contact Lenses
ق Emphysema
ق Chronic Cough
ق Tuberculosis
ق Asthma
ق Hay Fever
ق Latex Sensitivity
ق Allergies or Hives
ق Sinus Trouble
ق Radiation Therapy
ق Chemotherapy
ق Tumors

ق Hepatitis A/ Infectious B/ Serum
ق Venereal Disease
ق A.I.D.S.
ق H.I.V. Positive
ق Cold Sores/Fever Blisters
ق Blood Transfusions
ق Hemophilia
ق Sickle Cell Disease
ق Bruise Easily
ق Liver Disease
ق Yellow Jaundice
ق Neurological Disorders
ق Epilepsy or Seizures
ق Nervous/Anxious
ق Fainting or Dizzy Spells
ق Psychiatric/Psychological

6. Do you have or have you had any disease, condition or problem not listed:………………………………………………...Yes No
If yes please list:____

7. Do you use more than two pillows to sleep? ……………………………………………………………………...Yes No

8. Have you lost/gained more than 10 pounds in the past year? …………………………………………………………..Yes No

9. Women: Are you: Pregnant? Yes No If yes,__ months Nursing? Yes No Taking Birth Control Pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature: ______________________ Date: __________________________

Doctor Signature: _____________________________ Date: __________________________

GARY L. HARRIS, D.D.S., P.C.

Dental Information

Patient Name: ____

Reason for your visit today? ____

Date of last dental visit: ______________ Last Dental Cleaning: ____________ Last Full Mouth X-Rays: ______________

What was done at your last dental visit? ____

____

Previous Dentist's Name: ______________________________ Phone: ______________________

Address: ____
Number Street City/State Zip Code

How often do you have dental examinations? ____

How often do you brush your teeth? ______________________ How often do you floss? ______________________

What other dental aids do you use? (Interplak, toothpick, etc.) ______________________________

Do you have any dental problems now? Yes No

If yes, please describe: ____

Are any of you teeth sensitive to :

- Hot or Cold
- Sweets
- Biting or Chewing
- Have you noticed any mouth odors or bad taste
- Do you frequently get cold sores, blisters, or any other oral lesion

- **Do your gums bleed or hurt**
- Have your parents experienced gum disease or tooth loss
- Have you noticed any loose teeth or change in your bite
- Does food tend to become caught in your teeth
  If yes where ______________________________

Do you:

- Clench or grind your teeth while awake or asleep
- Bite your lips or cheek regularly
- Hold foreign objects with your teeth (pencils, pins, nails, fingernails)
- Mouth breathe while awake or asleep
- Have tired jaws, especially in morning
- Smoke/chew tobacco

Have you ever had:

- Orthodontic Treatment
- Oral Surgery
- Periodontal
- Your teeth/bite adjusted
- A bite plate or mouth guard
- A serious injury to mouth or head
  If so please describe, including cause:

____

Have you ever experienced:

- Clicking or popping of the jaw
- Pain (joint/ear/side of face)
- Difficulty in opening or closing mouth
- Headaches, neck aches, or shoulder aches
- Sore muscles (neck, shoulders)

- **Are you satisfied with your teeth's appearance**
- Would you like to keep your teeth
- Do you feel nervous about having treatment
  If so, what is your biggest concern? ____________

____

- Have you ever had an upsetting dental experience
  If yes please describe ______________________

Is there anything else about having dental treatment that you would-like us to know? ……………………………………………………………………Yes or No
If yes please describe: ____

____