PETER D. McCONNELL, D.D.S., P.C.

Patient Information

First Name: _____ Last Name: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Cell Phone: _____ Pager: _____

Date of Birth: _____ Social Security Number: _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Responsible Party

First Name: _____ Last Name: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Date of Birth: _____ Social Security Number: _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Insurance Information

Name of Insured: _____ ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Date of Birth: _____ SSN: _____ Employer: _____

Employer Address: _____

Insurance Company: _____ Insurance Phone: _____

Insurance Address: _____

Member ID: _____ Group Number: _____

Medications

List any medications you are currently taking:

_____

_____

_____

_____

Allergies

☐ Aspirin ☐ Sulfa
☐ Codeine ☐ Penicillin
☐ Iodine ☐ Barbiturates
☐ Latex ☐ Anesthetic
☐ Other _____

HEALTH HISTORY

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

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

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

DENTAL HISTORY

CHIEF ORAL COMPLAINT _____

DATE OF LAST DENTAL EXAM _____ CLEANING _____ X-RAYS _____ RESTORATIONS _____

ANY PREVIOUS MAJOR DENTAL TREATMENT, ☐ YES ☐ NO WHEN? _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING-INDICATE WITH A (✓)

- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums. How long _____
- ☐ Food impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ☐ Unusual sounds in ear while eating
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Unfavorable dental experience
- ☐ Complications from extractions
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Oral habits, i.e., fingernail biting
- ☐ Cigarettes, pipe or cigar smoking
- ☐ Texture of toothbrush _____
- ☐ Frequency of brushing _____
- ☐ Dental Floss
- ☐ Inter dental stimulators
- ☐ Water jet device
- ☐ Disclosing tablets or solution
- ☐ Fluoride supplements