PHILIP H. IFFLAND, D.D.S., Inc.
PERSONAL INFORMATION

Patient Name:_____ As Patient of Record

Address:_____

City:_____ State:_____ Zip:_____

Social Security #:_____ Date of Birth:_____

Home Phone:_____ Work Phone:_____ Ext:_____

Fax:_____ Cell:_____ Pager:_____

E-mail:_____

Place of Employment:_____

Do you have dental insurance currently in force? ☐Yes ☐No

With which company?_____ Insured's Date of Birth:_____

Insured's Place of Employment:_____ Insured's SS #:_____

Do you have Co-Insurance? ☐Yes ☐No Name of Co- insurance company:_____

Co-Insured's Name:_____ Co-Insured's D.O.B.:_____

Co-Insured's Employer:_____ Co-Insured's SS#:_____

Spouse's Name:_____ Spouse's D.O.B.:_____

Who is responsible for your account? Name:_____

Responsible Party's Address:_____

Responsible Party's Employer:_____ Resp. Party's SS#_____

Home Phone:_____ Work Phone:_____ Resp. Party's D.O.B.:_____

Dental Information and History

Whom may we thank for referring you to this office?_____
Do you want to keep your teeth? □Yes □No If no, why?_____
Can you come in for appointments on short notice? □Yes □No
Do you have a dental emergency or any dental complaints: Please describe:_____

_____

Have you ever had: (Please Circle)			Do you have or have you ever had: (Please Circle)					
Any teeth removed	Y	N	Noises around or in your jaw joints?	Y	N	□ Rt	□ Lt	□ Both
Root Canals?	Y	N	Soreness in your jaw or jaw joints?	Y	N	□ Rt	□ Lt	□ Both
Gum Treatment?	Y	N	Do you grind or clench your teeth?	Y	N	When?_____		
Braces?	Y	N	Do you have sore or bleeding gums?	Y	N	How Long?_____		
Oral Surgery?	Y	N	Do your teeth ache?	Y	N	When?_____		
Dental Implants?	Y	N						

DOCTOR'S NOTES

Please Allow Dr. Iffland To Complete. Thank You.

Previous DDS?_____ Last Visit:_____
Last CMX or Complete Exam:_____
Emergency? ☐Yes ☐No Nature of Emergency:_____

Br/Day_____Fl/Day_____ **Previous OHI?** ☐Yes ☐No **Perio?** ☐Yes ☐No **Caries?** ☐Yes ☐No
Specific and/or Special Notes:

MEDICAL HISTORY

Medical Doctor's Name:_____ Date of Last Medical Exam:_____

Are you under a physician's care now? _____If so, for what?_____

Are you taking any medications (Include tablets, pills, vitamins, etc.)_____

_____

Have you had any surgeries, hospitalizations, illnesses or health problems in the past five years? If so, please describe:

_____

_____

Describe your present state of health:_____

_____

Have any medical or dental procedures been prescribed for you that you have not had completed? If yes, describe_____

_____

Do you have or have you had any of the following:

Headaches, Head Pain, Jaw Pain?	Y N	Venereal disease, STD's(sexually transmitted diseases)?	Y N
Fainting spells, seizures, epilepsy?	Y N	HIV AIDS, ARC or do you have the AIDS virus in your body?.	Y N
Strokes, aneurysms?	Y N	Hepatitis, liver disease, jaundice?	Y N
Heart attack or heart problems?	Y N	Kidney disease?	Y N
Rheumatic fever?	Y N	Diabetes, Sugar problems?	Y N
Rheumatic heart disease?	Y N	Do you take a long time to heal?	Y N
Heart murmur, or Mitral Valve Prolapse?	Y N	Arthritis?	Y N
Prosthetic heart valve?	Y N	Prosthetic joint replacements?	Y N
Antibiotic premedication suggested prior to dental treatment?	Y N	Do you take medicines to help strengthen your bones (EX: Fossamax, Boniva, etc)?	Y N
A Pacemaker?	Y N	Have you ever used Phen-Phen?	Y N
Congestive heart failure?	Y N	Cancer diagnosed?	Y N
Nervous disorders?	Y N	Where in your body?_____	
Pain in your chest, shortness of breath, swollen ankles?	Y N	When?_____	
High blood pressure?	Y N	Received chemotherapy, radiation or other cancer treatment?	Y N
Low blood pressure?	Y N	Sores that did not heal in one week?	Y N
Blood disorders, anemia?	Y N	Women: Are you pregnant?	Y N
A blood test with unusual results?	Y N	Do you use tobacco?	Y N
What test?_____	Y N	What type, how often?_____	
Abnormal bleeding?	Y N	Chemical or alcohol dependency?	Y N
Why?_____	Y N	ALLERGIES:	
Do you bruise easily?	Y N	Are you sensitive or allergic to:	
Tuberculosis, pneumonia, or other lung disorders?	Y N	Penicillin	Y N
Asthma?	Y N	Codeine	Y N
Hay fever?	Y N	Novocaine, Lidocaine, or any local anesthetics	Y N
A persistent cough or do you cough up blood?	Y N	Aspirin	Y N
		Any metals (EX: nickel, gold, silver)?	Y N

Do you have ANY antibiotic allergies?_____

Do you have ANY other drug allergies?_____

Do you have ANY food allergies?_____

Do you have ANY other allergies?_____

Do you have ANY disease or condition not listed here?_____

I consent to whatever dental procedures and anesthetics are necessary for the treatment of the above named Patient of Record.

Date_____Signature_____

If not Patient, your status/relationship_____

Date:_____ Signature:_____

Date:_____ Signature:_____

Date:_____ Signature:_____