

Today's Date _____

How did you hear about us? (Name of patient if referral) _____

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ ST: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Employer: _____ Work Phone: _____

Email: _____

Marital Status: _____ Sex: M F Birth Date: _____ Social Security #: _____

Emergency Contact Name: _____ Emergency Contact Number: _____

Responsible Party (If patient is under 19)

Last Name: _____ First Name: _____ DOB: _____

Address: _____ City: _____ ST: _____ Zip: _____

Relation to Patient: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Dental Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Policy Holder's Social Security #: _____ Policy Holder's Date of Birth: _____

Name of Insured's Employer: _____ Phone # of Employer: _____

Insurance Company: _____ Policy Number: _____ Group #: _____

Secondary Insurance: Y / N _____

Medical History

Patient Name: _____ Birth Date: _____

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 If yes, please explain: _____
Physician's name _____ Phone _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No
- Are you on a special diet? Yes No
- Describe your current physical health. Good Fair Poor
- Do you use tobacco? Yes No
- Do you use a controlled substance? Yes No

Women: Are you pregnant/trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain _____

Dental History

Why have you come to the dentist today? _____

- Are you currently in pain? Yes No
- Do you require antibiotics before dental treatments? Yes No
- Describe your current dental health. Good Fair Poor
- Have you ever had serious/difficult problems associated with any previous dental work? Yes No
- If yes, please explain _____
- How many times per day do you brush? _____
- How many times a week do you floss? _____
- Type of bristles on your toothbrush. Hard Medium Soft
- Have you ever had gum treatment? Yes No
- Do your gums ever bleed? Yes No
- Have you ever had periodontal disease? (gum disease) Yes No
- Do you now or have you ever experienced pain/discomfort in your jaw joint? (TMJ/TMD) Yes No
- Are your teeth sensitive to heat, cold, or anything else? Yes No
- Do you have any loose teeth? Yes No
- Do you still have wisdom teeth? Yes No
- Would you like whiter teeth? Yes No
- Are you happy with your smile? Yes No
- If no, what would you change? _____

To the best of my knowledge, all of the preceding answers are true and correct. I will inform the dental staff at the next appointment if I ever have any change in my health, or if my medications change.

Signature of Patient, Parent, or Guardian

Date

Do you have any of the following?

Abnormal Bleeding/Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No
AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No
Alcohol/Drug Abuse	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No
Artificial Bones/Joints/Valves	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Lupus	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No
Colitis	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatment	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Emphysema	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Fainting Spells	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No
Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Other _____	

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