PATIENT INFORMATION

Welcome to our office. The information provided on this form is important to your dental health. If there have been any changes in your health, please inform us. If you have questions, please don't hesitate to ask. All information is confidential.

Name: ____ Date of Birth: _____________ Sex: _____ Age: _____

Address: ____ City: __________________ State: _____ Zip: _______

Home Phone: ______________________ Cell Phone: _______________________ Height: ________ Weight: ________

Employer: ____________________________ Occupation: __________________________ Work Phone: _____________

SSN: ___________________ Email: _______________________ Referred to us by: ______________________________

Are any of your family members patients of this practice? Y N Name: ____________________ Relationship: __________

Emerg. contact name: ________________________________ Relationship: ________________ Phone: _____________

Primary Dental Insurance (Leave blank if none)

Insurance Company: _____________________________

Policy #: ________________ Group #: ______________

Subscriber's Name: ______________________________

DOB: ________________ SSN: ___________________

Billing Information (if responsible party is other than patient)

Billing Name: ___________________________________

Billing Address: _________________________________

City: ______________________ State: _____ Zip: _______

Phone: _________________ SS #: __________________

DENTAL HEALTH HISTORY

Name of previous dentist: _________________________________ Last visit: ______________ Last x-rays: _____________

What is the reason for this appointment? ____

Are any of your teeth sensitive to:

Hot or Cold? …………………………………………………. Y N

Sweets? …………………………………………………… Y N

Biting or pressure? ……………………………………….. Y N

Have you ever noticed any unpleasant tastes or odors? ….. Y N

Do you frequently get cold sores, blisters or any mouth sores? …………………………………………………… Y N

Do you:

Clench or grind your teeth while awake or asleep? ……….. Y N

Have tired jaws, especially early in the morning? ………….. Y N

Bite your lips or cheeks regularly? …………………………… Y N

Hold objects with your teeth? (pencils, pins, nails,, etc.) ….. Y N

Breath mainly through your mouth? ………………………… Y N

Snore? ………………………………………………………... Y N

Have you ever experienced:

Clicking or popping of the jaw? ……………………………… Y N

Pain in your face or near your ears? ……………………….. Y N

Difficulty opening or closing the mouth? …………………….. Y N

Frequent headaches, neck aches, or shoulder aches? …… Y N

Do your gums bleed or hurt? ………………………….. Y N

Have your parents had gum disease or tooth loss? …… Y N

Have you noticed any loose teeth or bite changes? …… Y N

Does food tend to become caught between your teeth? Y N

Have you ever had:

Orthodontic treatment? Y N

Oral surgery? ………………………………………………. Y N

Periodontal Treatment? …………………………………… Y N

Gum Surgery? ……………………………………………… Y N

If so, when? ________________________________

By whom? __________________________________

A bridge? If so, when? _______________________ Y N

A serious injury to the mouth or head? ………………….. Y N

If so, please describe: _______________________

____

Are you dissatisfied with the appearance of your teeth? Y N

Are your teeth discolored? ……………………………….. Y N

Are your teeth crooked? ………………………………….. Y N

If there anything else about dental treatment that you would like us to know, please describe. ______________________

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Notes: ____

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MEDICAL HEALTH HISTORY

Name of your medical doctor(s): ____ Phone number: ________________

Condition being treated: ____ Date of last visit: ________________

Please list any medications you are taking (please include *any* natural remedies, supplements, and non-prescription drugs): ____

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Please list any past surgeries, hospitalizations or serious illnesses (please note any complications): _________________

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

Condition	Y	N
Heart Problems	Y	N
Chest pain/angina	Y	N
Shortness of breath	Y	N
Blood pressure abnormality (circle: high or low)	Y	N
Heart murmur	Y	N
Heart valve defect (ex. mitral valve prolapse)	Y	N
Artificial heart valve	Y	N
Heart attack	Y	N
Rheumatic fever	Y	N
Pacemaker	Y	N
Bypass surgery	Y	N
Swollen ankles	Y	N
Stroke	Y	N
Any bleeding disorders	Y	N
Easy bruising/nosebleeds	Y	N
Abnormal or prolonged bleeding	Y	N
Blood disease (anemia/hemophilia)	Y	N
Blood transfusion	Y	N
Sickle cell trait/anemia	Y	N
Lung/Breathing Problems	Y	N
Hay fever/Sinus problems	Y	N
Tuberculosis	Y	N
Emphysema/Bronchitis	Y	N
Skin rashes	Y	N
Asthma	Y	N
Intestinal Problems	Y	N
Ulcers	Y	N
Weight gain or loss (significant)	Y	N
Special diet	Y	N
Constipation/Diarrhea	Y	N
Kidney or bladder problems	Y	N
Bone, Joint, or Muscular Problems	Y	N
Arthritis	Y	N
Back or neck pain	Y	N
Joint replacement (ex. hip, pins, or implants)	Y	N
Dizziness, fainting spells, seizures, epilepsy or other neurological disorder	Y	N
Frequent or severe headaches	Y	N

Condition	Y	N
Thyroid problems	Y	N
Persistent or bloody cough	Y	N
Adrenal/pituitary problems	Y	N
Frequent infections/difficulty healing	Y	N
Cancer/Tumor/Other growths	Y	N
Surgical removal?	Y	N
Chemotherapy or Radiation?	Y	N
Antibiotic Premedications required	Y	N
Allergic/Adverse reaction to:		
Local anesthetics ("Novocaine")	Y	N
Penicillin or other antibiotics	Y	N
Sulfa drugs	Y	N
Aspirin, Acetaminophen, or Ibuprofen	Y	N
Codeine, Demerol, or other narcotics	Y	N
Reaction to metals	Y	N
Latex or rubber	Y	N
Other ______________________________________		
Diabetes	Y	N
Urinate more than 6 times a day	Y	N
Thirsty or mouth is dry much of the time	Y	N
Family history of diabetes	Y	N
Do you drink alcohol?	Y	N
If so, how much ____________________________		
Do you smoke or use chewing tobacco?	Y	N
If so, how much ____________________________		
Hepatitis, jaundice, or liver trouble	Y	N
If hepatitis, indicate type: A B C		
Herpes or other STD	Y	N
HIV-positive/AIDS	Y	N
Glaucoma	Y	N
Psychological/Mental disorder	Y	N
Swollen glands or fever	Y	N
History of alcohol or drug addiction	Y	N
Anorexia or bulimia	Y	N
Have you taken any steroids in the past 6 months?	Y	N
Women:	Y	N
Are you pregnant?	Y	N
Are you nursing?	Y	N

Do you have any current health conditions not listed above, please describe:

____

Patient/Parent Signature: ________________________________ Date: ______________

Doctor Signature: ____________________________________ Date: ______________

Doctor Notes: ____

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