PATIENT INFORMATION

First Name: _____ MI: _____ Last: _____ Nick Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

DOB: _____ ❑ Male ❑ Female SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____

State ID/Driver's License #: _____ E-mail Address: _____

Name of Physician: _____ Physician Phone: _____

In case of Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about our office? _____

Patient Health History

Do you have a history of:

	Yes	No		Yes	No		Yes	No		Yes	No
A.I.D.S/HIV Positive	❑	❑	Excessive Bleeding	❑	❑	Jaundice	❑	❑	Respiratory Problems/Disorders	❑	❑
Alcoholism	❑	❑	Epilepsy	❑	❑	Kidney Disease	❑	❑	Rheumatic Fever	❑	❑
Allergies	❑	❑	Glaucoma	❑	❑	Kidney Dialysis	❑	❑	Rheumatism	❑	❑
Anemia	❑	❑	Hay fever	❑	❑	Latex Sensitivity	❑	❑	Scarlet Fever	❑	❑
Arthritis	❑	❑	Head injuries	❑	❑	Lupus	❑	❑	Seizures/Fainting spells	❑	❑
Asthma	❑	❑	Hearing Impaired	❑	❑	Low Blood Pressure	❑	❑	Sinus Problems	❑	❑
Blood Disease	❑	❑	Heart Disease	❑	❑	Malignancies	❑	❑	Stomach Ulcers	❑	❑
Bone Disease	❑	❑	Heart Valve, Murmur	❑	❑	Mitral Valve Prolapse	❑	❑	Stroke	❑	❑
Cancer	❑	❑	Hepatitis/Liver Disease	❑	❑	Neck & Back Problems	❑	❑	Thyroid Disease	❑	❑
Chemical Dependency	❑	❑	Type(s) _____			Nervous Problems/Disorders	❑	❑	Tuberculosis	❑	❑
Chest Pain	❑	❑	Hepatitis Carrier	❑	❑	Pacemaker	❑	❑	Tumors or growths	❑	❑
Circulatory Problems	❑	❑	High Blood Pressure	❑	❑	Prosthetic Joints	❑	❑	Ulcers	❑	❑
Convulsions/Seizures	❑	❑	Hip or Joint replacement	❑	❑	Psychiatric Care	❑	❑	Venereal Disease	❑	❑
Diabetes	❑	❑	HPV	❑	❑	Radiation Treatment	❑	❑			

Medical Questions

List any medications you are taking including nonprescription drugs:

_____

_____

_____

Are you allergic to any medications? ❑ Yes ❑ No If yes, please list below:

_____

_____

Are you in good health? ❑ Yes ❑ No

Date of last medical exam: _____

Have you ever been hospitalized? ❑ Yes ❑ No If yes, what was the problem

_____

_____

Do you have any disease/problem you think we should know about? ❑ Yes ❑ No

_____

_____

_____

_____

Have you had a transplant operation that has depressed your immune system? ❑ Yes ❑ No

Have you had an allergic reaction to Bananas? ❑ Yes ❑ No

Do you smoke or chew tobacco? ❑ Yes ❑ No

Have you had Heart Surgery? ❑ Yes ❑ No

Are you now under the care of an MD? ❑ Yes ❑ No

Are you taking or have you ever taken bisphosphonates? (Fosamax or Actonel for osteoporosis, chemotherapy, etc) ❑ Yes ❑ No

FOR WOMEN ONLY:

Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Expected delivery date: _____

Are you nursing/breastfeeding? ❑ Yes ❑ No

Is there a possibility of pregnancy? ❑ Yes ❑ No

NOTE: Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Date: _____

Dr. Signature: _____

Date: _____

Reviewed by: _____

Dental History Information

Date of last dental visit? _____

Name of your previous dentist _____

Reason for today's visit? _____

Have you ever had an oral cancer screening? ❑ Yes ❑ No

How often do you floss your teeth? _____

Do your gums bleed when you brush? ❑ Yes ❑ No

Have you or a family member ever been treated for periodontal disease? ❑ Yes ❑ No

Have you ever had complications from an extraction? ❑ Yes ❑ No

Have you ever had a popping or clicking near your ear when you chew? ❑ Yes ❑ No

Are you prone to frequent headaches? ❑ Yes ❑ No

Do you grind or clench your teeth? ❑ Yes ❑ No

Do you have sores, blisters or swelling on your gums lips or cheeks? ❑ Yes ❑ No

Have you ever had orthodontic treatment? ❑ Yes ❑ No

Do you snore? ❑ Yes ❑ No

Do you have problems with bad breath? ❑ Yes ❑ No

Have you ever had an allergic reactions to a crown, metal filling or dental appliance? ❑ Yes ❑ No

Have you ever used an electric toothbrush? ❑ Yes ❑ No

Are your teeth sensitive to hot, cold or pressure? ❑ Yes ❑ No

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

If you could change something about your smile what would it be:

- ❑ Whiter
- ❑ Straighter
- ❑ Close space
- ❑ replace black mercury filling with tooth colored restorations
- ❑ repair chipped teeth
- ❑ replace missing teeth
- ❑ less gums showing
- ❑ replace old crowns or caps that don't match

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Patient: _____ Date: _____

Parent/Guardian (if patient is a minor): _____ Date: _____