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: _____

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

Dr. Signature: _____

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

Date: _____

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: _____

Reviewed by: _____