PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient's name ______________________________ Preferred name ______________ Birth date__________

If minor, parents names ______________________ Home phone ___________ Cell phone ____________

Email Address____

Mailing address ____________________________ City _______________State _______ Zip _________

Employer ___________________________ Occupation _________________Work phone ____________

Social Security number _________________ Whom may we thank for referring you to our office?________________

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart disease or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Stroke
- ❑ Heart attack
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis
- ❑ Lung disease/ emphysema
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Sexually transmitted disease
- ❑ Stomache ulcers/ GERD
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Radiation therapy
- ❑ Glaucoma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma
- ❑ Thyroid problems
- ❑ Other:______________________________
- ❑ Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin
- ❑ Other Antibiotic (please list)_______________
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____________________________

Please list all medication you are currently taking including non-prescription medicine:

____
____
____

Women:

- ❑ Are you pregnant or think you may be pregnant?
  Expected delivery date: ___________
- ❑ Are you nursing?
- ❑ Taking hormones or contraceptives?
  ____

PATIENT DENTAL HISTORY

Do you snore or stop breathing in your sleep? Yes/ No

- ❑ My gums bleed while brushing or flossing
- ❑ My teeth are sensitive to hot or cold liquids/foods
- ❑ I feel pain in my teeth
- ❑ I have sores or lumps in or near my mouth
- ❑ I have been diagnosed with gum disease
- ❑ I have frequent headaches
- ❑ I clench or grind my teeth
- ❑ I bite my lips or cheeks frequently
- ❑ I've had difficult extractions in the past
- ❑ I've had orthodontic treatment
- ❑ I've had head, neck or jaw injuries
- ❑ I've experienced the following problems in my jaw:
  - ❑ Clicking
  - ❑ Pain (joint, ear, side of face)
  - ❑ Difficulty in opening or closing
  - ❑ Difficulty in chewing
- ❑ I've had no instruction on the correct method of brushing my teeth
- ❑ I've had no instruction on the proper care of my gums

Name of your physician:________________Office Phone:______________Date of last exam:_________________

Do you have any disease, condition, or problem not listed above?______________________________

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Signature of patient (or parent) ________________________________ Date ____________