PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information you provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient Name: _____ Date of Birth: _____ Sex: _____ Age: _____

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

Billing Address (If Different): _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ E-mail: _____ Driver's License: _____ State: _____

SS#: _____ Employer / Occupation: _____ Business Phone: _____

Primary Emergency Contact #1: _____ Phone: _____

Secondary Emergency Contact #2: _____ Phone: _____

Primary Dental Insurance: _____ Group #: _____

Secondary Dental Insurance: _____ Group #: _____

Subscriber's Name: _____ Date of Birth: _____ SS #: _____

Name of your Medical Doctor: _____ Date of last visit to Medical Doctor: _____

Name of Previous Dentist: _____ Date of last visit to Dentist: _____

Referred to us by: _____

DENTAL & MEDICAL HEALTH HISTORY

For the following questions, circle yes or no. Your answers for our records will be confidential. By signing below, the questions on this form will be answered accurately.

	YES	NO
Are you apprehensive about dental treatment?	○	○
Have you had problems with previous dental treatment?	○	○
Do you gag easily?	○	○
Do you wear dentures?	○	○
Do you have difficulty chewing your food?	○	○
Do you avoid brushing any part of your mouth because of pain?	○	○
Do your gums bleed easily?	○	○
Do your gums feel swollen of tender?	○	○
Have you ever noticed slow-healing sores in or about your mouth?	○	○
Are your teeth sensitive?	○	○
☐ Hot ☐ Sweets ☐ Pressure		
☐ Cold ☐ Sour ☐ Air		
Location: _____ Duration: _____		
Are you dissatisfied with the appearance of your teeth?	○	○
How often do you brush your teeth?		
How often do you floss your teeth? _____		
Does your jaw make noise so that it bothers you or others?	○	○
Do you grind or clench your jaws frequently?	○	○
Does your jaw get stuck so that you can't open freely?	○	○
Does it hurt when you chew or open wide to take a bite?	○	○
Do you have earaches or pain in front of the ears?	○	○

	YES	NO
Do you have any jaw symptoms or headaches upon awakening in the morning?	○	○
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	○	○
Do you have a temporomandibular (jaw) disorder?	○	○
Do you have pain in the face, cheeks, jaws, joints, throat or temples?	○	○
Are you aware of an uncomfortable bite?	○	○
Have you had a blow to the jaw (trauma)?	○	○
Heart Problems:		
Chest Pains	○	○
Shortness of Breath	○	○
Blood Pressure	○	○
Heart Murmur	○	○
Heart Valve	○	○
Rheumatic Fever	○	○
Pacemaker	○	○
Artificial Heart Valve	○	○
Blood Problems:		
Easy Bruising	○	○
Blood Transfusion	○	○
Abnormal Bleeding	○	○
Blood Disease (Anemia)	○	○

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	YES	NO
Allergy Problems:		
Hay Fever	○	○
Sinus Problems	○	○
Skin Rashes	○	○
Taking Allergy Medications	○	○
Asthma	○	○
Intestinal Problems:		
Ulcers	○	○
Weight Gain or Loss	○	○
Special Diet	○	○
Constipation / Diarrhea	○	○
Kidney or Bladder Problems	○	○
Bone or Joint Problems:		
Arthritis	○	○
Back or Neck Pain	○	○
Joint Replacement (Total Hip, Pins, Implants)	○	○
Diabetes:		
Urinate more that six times a day	○	○
Thirsty or mouth is dry	○	○
Family History of Diabetes	○	○
Are you allergic, or have reacted adversely, to any of the following?		
Local Anesthetics	○	○
Penicillin of Other Antibiotics	○	○
Sulfa Drugs	○	○
Barbiturates, Sedatives, or Sleeping Pills	○	○
Aspirin, Acetaminophen, Ibuprofen	○	○
Codeine, Demerol, or Other Narcotics	○	○
Reaction to Metals	○	○
Latex of Rubber Dam	○	○
Other _____		
Fainting Spells, Seizures or Epilepsy	○	○
Stroke(s)	○	○
Frequent of Severe Headaches	○	○
Thyroid Problems	○	○
Persistent Cough or Swollen Glands	○	○
Cancer / Tumor	○	○
Tuberculosis or Respiratory Disease	○	○
Hepatitis, Jaundice or Liver Trouble	○	○
Vaccination Date _____		
Herpes or Other STD	○	○
HIV-Positive or Aids	○	○
Glaucoma	○	○
Head, Neck, Face Injury	○	○
Have you ever been premedicated prior to a treatment?	○	○

	YES	NO
Are you currently using any tobacco?	○	○
If so, how much? _____		
Do you drink?	○	○
If so, how much? _____		
Do you have any disease, condition or problem not listed previously that we should know about? _____		
During the past 12 months, have you taken any of the following?		
Antibiotics or Sulfa Drugs	○	○
Anticoagulants	○	○
High Blood Pressure	○	○
Tranquilizers	○	○
Insulin, Orinase or Similar Drugs	○	○
Aspirin	○	○
Digitalis of Drugs for Heart Trouble	○	○
Nitroglycerin	○	○
Cortisone (Steroids)	○	○
Natural Remedies	○	○
Non-prescription Drug / Supplements	○	○
Other _____		
Women:		
Are you taking any contraceptives?	○	○
Are you pregnant?	○	○
If so, expected delivery date _____		
Are you nursing?	○	○
Have you reached menopause?	○	○
If so, any symptoms? _____		

Parent / Patient Signature: _____

Date: _____ Dentist Initial: _____

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