Patient History

Name _____Male__Female__Date of Birth_____

Residence_____City_____Zip_____

Home Phone_____Work Phone_____Cell Phone_____

Employer_____ City_____ _____

Present Position_____How long held_____

Spouse (if minor-parent)_____Employer_____

Present Position_____Business Phone_____

Who referred you to our office?_____

Person financially responsible for the account_____

Dental Insurance Company_____

Name of Insured_____SS#._____Date of Birth_____

Medical History

Name of physican_____

Are you in good health?_____

Are you currently under the care of a physician?_____For_____

Are you taking any drugs or medication?_____List_____

For_____

Are you allergic to: Penicillin_____Codeine_____Anesthetic_____Latex_____

Other_____

To your knowledge, is there any reason why any dental procedure should not be performed on you?_____

Explain:_____

Have you had or do you now have:

Heart trouble	Rheumatic fever	Diabetes	Heart murmur
Bleeding problems	Drug reactions	Pacemaker	HIV/AIDS
High blood pressure	Respiratory problems	Epilepsy	Asthma
Nervous disorder	Arthritis	Headaches	Ulcers
Tumor/cancer	Hepatitis	Stroke	Other
Joint replacement			

Explain:_____

DATE:_____**SIGNATURE**_____

Email----------

Dental History

Are your teeth sensitive to:_____heat_____cold_____sweets_____biting pressure

If yes, where?_____

Does food catch between your teeth?_____ Yes No

If yes, where?_____

Do your gums bleed while brushing?_____ Yes No

Have you ever noticed any gum swelling around any teeth?_____ Yes No

Have your gums ever been treated?_____ Yes No

Do you clench or grind your teeth?_____ Yes No

Do your jaws ever feel tired and achy_____ Yes No

Have you had any injuries to the face or jaw?_____ Yes No

Have you had orthodontics?_____ Yes No

If you have any missing teeth, have they been replaced?_____ Yes No

If not, why?_____

If yes, are you comfortable with the replacement?_____ Yes No

Have you had a complete dental examination, including x-rays, within the past 3 years?___ Yes No

Have you been instructed regarding proper home care?_____ Yes No

Do you use dental floss?_____Yes No

Have your wisdom teeth been extracted?_____ Yes No

When was your last dental appointment and for what purpose?_____

Please add anything you feel is important._____

Signature_____**Date**_____

Payment is expected when services are rendered,
unless other arrangements are made in advance.