Patient Information

Date _____ Email _____

SSN_____ Birthdate _____ Age _____ Sex __M __F

Last Name _____ First Name _____ M.I. ___ Preferred Name _____

Address _____ City _____ State ____ Zip _____

Married ___ Widowed ___Single ___Separated ___Divorced ___Partnered____, ___yrs.

Phone Numbers

Home (____) _____ Cell (____) _____ Work (____) _____ Ext _____

Spouse's Work (____) _____ Best time and place to reach you _____

In case of emergency, contact (Specify someone not living in your household)

Name _____ Relationship _____

Home phone (____) _____ Work Phone (____) _____

Patient Employer/ School _____ Employer/ School Phone Number (___) _____

Spouse's Name _____ Birthdate _____ SSN _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____ Relationship to patient _____

Dental Insurance Company Name _____ Group # _____

Subscriber's Name _____ Birthdate _____ SSN /ID _____

Relationship to Patient _____ Is patient covered by additional insurance? ___Yes ___ No

Secondary Dental Insurance Company Name _____ Group # _____

Smile Evaluation- Please check one box in each line that applies

☐My mouth is very comfortable ☐My mouth is moderately comfortable ☐ My mouth is uncomfortable

☐My smile is excellent ☐I would like to change my smile ☐I am unconcerned about my smile

☐I will do what I must to keep my teeth ☐I want to keep my teeth but only within a certain budget of time and money.

☐I've done the dentistry recommended to me ☐I've NOT done dentistry recommended to me

☐*Never been recommended*

My dental health is ☐Excellent ☐Good ☐Fair ☐Poor

Dental History Part I

What is the reason for your visit today? _____ Are you in pain now Yes No

Date of Last dental visit _____Last dental cleaning _____ Last Full Mouth X-Rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone Number (___) _____

Address _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids to you use? (waterpik, toothpicks, etc.) _____

Dental History Part II

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or chewing?	Yes	No
Have you noticed any mouth Odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	no
Have you noticed any loose teeth Or change in your bite?	Yes	no
Does food tend to become caught In between your teeth?	Yes	no

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	no
Bite your lips or cheeks regularly?	Yes	no
Hold objects with your teeth? (pencils, pins, fingernails)	Yes	no
Mouth breathe while awake or asleep?	Yes	no
Have tired jaws, especially in the morning?	Yes	no
Snore/ sleeping disorders?	Yes	no
Smoke/ chew tobacco?	Yes	no
Have you ever needed to pre-medicate prior to dental treatment?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	no
Oral Surgery?	Yes	no
Periodontal Treatment	Yes	no
Your teeth ground or bite adjusted?	Yes	no
A bite plate or mouth guard?	Yes	no
A serious injury to the mouth or head?	Yes	no

If so, please describe, including cause _____

_____

Have you experienced:

Clicking or popping of the jaw?	Yes	no
Pain? (joint, ear, side of face)	Yes	no
Difficulty opening or closing mouth?	Yes	no
Difficulty chewing on either side?	Yes	no
Head, neck or shoulder pain?	Yes	no
Sore muscles? (neck/shoulders)	Yes	no

Are you satisfied with your teeth's appearance? Yes no

Do you feel nervous about dental treatment? Yes no

If so, what is your biggest concern? _____

_____

Have you ever had an upsetting dental experience? Yes no

If so, please describe _____

_____

Is there anything else about having dental treatment that you would like us to know? Yes no

If yes, please describe _____

MEDICAL HISTORY PART I

1. Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what? _____

Physician's Name _____ Phone (____) _____

Address _____City _____ State ____ Zip _____

2. Have you ever taken bisphosphonates for Osteoperosis such as Actonel, Fosomax, Boniva and Reclast? Yes No

3. Have you been a patient in the hospital during the past five years? Yes No

4. Have you lost or gained more than 10 pounds in the past year? Yes No

5. Women: Are you pregnant or think you may be pregnant? Yes, ____ months No

Nursing? Yes No

Do you use birth control? Yes No

Have you ever needed to pre-medicate prior to dental treatment? Yes No

Medical History Part II

Please indicate which of the following you have had, or have at present:

AIDS/HIV	Yes	No	Kidney disease	Yes	No
Alcohol Addiction	Yes	No	Liver disease	Yes	No
Arthritis, Rheumatism	Yes	No	Low blood pressure	Yes	No
Anemia	Yes	No	Mitral valve prolapse	Yes	No

Artificial heart valves	Yes	No	Nervous Problems	Yes	No
Artificial Joints	Yes	No	Neurological disorders	Yes	No
Asthma	Yes	No	Pacemaker	Yes	No
Back Problems	Yes	No	Psychiatric care	Yes	No
Bleeding abnormally with			Radiation Treatment	Yes	No
Extractions or surgery	Yes	No	Recreational Drugs	Yes	No
Blood Disease	Yes	No	Respiratory disease	Yes	No
Breast Augmentation	Yes	No	Smoke Cigarettes	Yes	No
Cancer	Yes	No	Rheumatic Fever	Yes	No
Chemotherapy	Yes	No	Scarlet Fever	Yes	No
Chemical dependency	Yes	No	Shortness of Breath	Yes	No
Circulatory Problems	Yes	No	Sinus Trouble	Yes	No
Congenital Heart Lesions	Yes	No	Skin Rash	Yes	No
Cortisone Treatments	Yes	No	Special Diet	Yes	No
Cough, persistent or bloody	Yes	No	Stroke	Yes	No
Diabetes	Yes	No	Swollen Feet or Ankles	Yes	No
Emphysema	Yes	No	Swollen Neck Glands	Yes	No
Epilepsy	Yes	No	Smokeless Tobacco	Yes	No
Fainting/Dizziness	Yes	No	Tonsillitis	Yes	No
Headaches	Yes	No	Tuberculosis	Yes	No
Heart Murmur	Yes	No	Tumor/Growth on neck	Yes	No
Heart (surgery, disease, attack)	Yes	No	Thyroid Problems	Yes	No
Hemophilia	Yes	No	Weight loss unexplained	Yes	No
Hepatitis, Type_____	Yes	No			
Herpes / Cold Sores	Yes	No	Do you wear contact lenses	Yes	No
High Blood Pressure	Yes	No	Do you take aspirin daily	Yes	No
Jaundice	Yes	No	Blood Thinners	Yes	No

Do you currently have or have you had any disease, conditions or problems not listed? Yes No
If yes please list_____

Allergies

___ Aspirin ___Barbiturates (sleeping pills) ___Codeine ___Iodine ____Latex
___Local Anesthesia ___Penicillin ___ Sulfa ___Other_____

Medications
List any Medications you are currently taking and the correlation dosage:
_____
_____
_____
_____
Pharmacy Name: _____Phone #_____

Signature
I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my heath or medication(s).

_____/___/____ _____/____/___
Patient/Guardian Signature Date Doctors Signature Date