



## 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 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, please don't hesitate to ask.

### General Information

Patient name \_\_\_\_\_ Today's date \_\_\_\_\_

Social Security No. \_\_\_\_\_ Date of birth \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Driver's license No. \_\_\_\_\_

Home address \_\_\_\_\_ Phone Cell phone \_\_\_\_\_

Billing address (if different from above) \_\_\_\_\_

Employer/occupation Business phone \_\_\_\_\_

Spouse's name \_\_\_\_\_ Spouse's phone \_\_\_\_\_

Emergency phone (other than spouse) \_\_\_\_\_

Primary dental insurance Group No. \_\_\_\_\_

Secondary dental insurance Group No. \_\_\_\_\_

Subscriber's name \_\_\_\_\_

Subscriber's Social Security No. \_\_\_\_\_

Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

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 Health History

	Yes	No		Yes	No
Are you apprehensive about dental treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever noticed slow-healing sores in or around your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had problems with previous dental treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>	Are your teeth sensitive? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you gag easily? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you feel twinges of pain when your teeth come in contact with: _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures? _____	<input type="checkbox"/>	<input type="checkbox"/>	Hot foods or liquids? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>	Cold foods or liquids? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty chewing your food? _____	<input type="checkbox"/>	<input type="checkbox"/>	Sour foods? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew on only one side of your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>	Sweets? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid brushing any part of your mouth because of pain? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you take fluoride supplements? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed easily? _____	<input type="checkbox"/>	<input type="checkbox"/>	Are you dissatisfied with the appearance of your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you floss? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you prefer to save your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums feel swollen or tender? _____	<input type="checkbox"/>	<input type="checkbox"/>			

## Dental Health History (Continued)

	Yes	No
Do you want complete dental care? _____	<input type="checkbox"/>	<input type="checkbox"/>
How often do you brush? _____	<input type="checkbox"/>	<input type="checkbox"/>
How often do you floss? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does your jaw make noise so that it bothers you? _____	<input type="checkbox"/>	<input type="checkbox"/>
or others? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your jaws frequently? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your jaws ever feel tired? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does your jaw get stuck so that you can't open freely? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does it hurt when you chew or open wide to take a bite? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have earaches or pain in front of the ears? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have jaw symptoms or headaches upon awaking in the morning? _____	<input type="checkbox"/>	<input type="checkbox"/>

Does jaw pain or discomfort affect your appetite, sleep, daily routine or other activities? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you find jaw pain or discomfort extremely frustrating or depressing? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a temporomandibular (jaw) disorder (TMD)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain in the face, cheeks, jaws, joints, throat, or temples? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you unable to open your mouth as far as you want? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of an uncomfortable bite? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a blow to the jaw (trauma)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you a habitual gum chewer or pipe smoker? _____	<input type="checkbox"/>	<input type="checkbox"/>

## Medical Health History

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

Heart problems _____	<input type="checkbox"/>	Special diet _____	<input type="checkbox"/>
Chest pain _____	<input type="checkbox"/>	Constipation/diarrhea _____	<input type="checkbox"/>
Shortness of breath _____	<input type="checkbox"/>	Kidney or bladder problems _____	<input type="checkbox"/>
Blood pressure problem _____	<input type="checkbox"/>	Fainting spells, seizures or epilepsy _____	<input type="checkbox"/>
Heart murmur _____	<input type="checkbox"/>	Stroke(s) _____	<input type="checkbox"/>
Heart valve problem _____	<input type="checkbox"/>	Frequent or severe headaches _____	<input type="checkbox"/>
Taking heart medication _____	<input type="checkbox"/>	Thyroid problems _____	<input type="checkbox"/>
Rheumatic fever _____	<input type="checkbox"/>	Persistent cough or swollen glands _____	<input type="checkbox"/>
Pacemaker _____	<input type="checkbox"/>	Premedications required by physician _____	<input type="checkbox"/>
Artificial heart valve _____	<input type="checkbox"/>	Cancer/tumor _____	<input type="checkbox"/>
Blood problems _____	<input type="checkbox"/>	Diabetes _____	<input type="checkbox"/>
Easy bruising _____	<input type="checkbox"/>	Urinate more than six times a day _____	<input type="checkbox"/>
Frequent nosebleed/Abnormal bleeding _____	<input type="checkbox"/>	Thirsty or mouth is dry much of the time _____	<input type="checkbox"/>
Blood disease _____	<input type="checkbox"/>	Family history of diabetes _____	<input type="checkbox"/>
Anemia _____	<input type="checkbox"/>	Tuberculosis or other respiratory disease _____	<input type="checkbox"/>
Ever require a blood transfusion? _____	<input type="checkbox"/>	Do you drink alcohol? _____	<input type="checkbox"/>
Allergy problems _____	<input type="checkbox"/>	If so, how much? _____	
Hay fever _____	<input type="checkbox"/>	Hepatitis, jaundice or liver trouble _____	<input type="checkbox"/>
Sinus problems _____	<input type="checkbox"/>	Herpes or other STD _____	<input type="checkbox"/>
Skin rashes _____	<input type="checkbox"/>	HIV positive/AIDS _____	<input type="checkbox"/>
Taking allergy medication _____	<input type="checkbox"/>	Glaucoma _____	<input type="checkbox"/>
Asthma _____	<input type="checkbox"/>	Do you wear contact lenses? _____	<input type="checkbox"/>
Intestinal problems _____	<input type="checkbox"/>	Head injury _____	<input type="checkbox"/>
Ulcers _____	<input type="checkbox"/>	Epilepsy or other neurologic disease _____	<input type="checkbox"/>
Weight gain or loss _____	<input type="checkbox"/>	History of alcohol or drug abuse _____	<input type="checkbox"/>

## Medical Health History (Continued)

During the past 12 months, have you taken any of the following?

	Yes	No
Antibiotics or sulfa drugs _____	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants (e.g., Coumadin) _____	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure medicine _____	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers _____	<input type="checkbox"/>	<input type="checkbox"/>
Insulin, Orinase or similar drug _____	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____	<input type="checkbox"/>	<input type="checkbox"/>
Digitalis or drugs for heart trouble _____	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerin _____	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone (steroids) _____	<input type="checkbox"/>	<input type="checkbox"/>
Natural remedies _____	<input type="checkbox"/>	<input type="checkbox"/>
Nonprescription drug/supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

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

	Yes	No
Local anesthetics ("Novocain") _____	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives or sleeping pills _____	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, acetaminophen or ibuprofen _____	<input type="checkbox"/>	<input type="checkbox"/>
Codeine, Demerol or other narcotics _____	<input type="checkbox"/>	<input type="checkbox"/>
Metals _____	<input type="checkbox"/>	<input type="checkbox"/>
Latex or rubber dam _____	<input type="checkbox"/>	<input type="checkbox"/>

Please list current medications:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Women:

	Yes	No
Are you taking contraceptives or other hormones? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, expected delivery date _____		
Are you nursing? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you reached menopause? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, do you have any symptoms? _____		

Date \_\_\_\_\_

Patient signature/legally authorized representative \_\_\_\_\_

Relationship \_\_\_\_\_

Printed name if signed on behalf of the patient \_\_\_\_\_

Date \_\_\_\_\_

Dentist signature \_\_\_\_\_