Patient's Name_____ Home Phone_____

Email Address_____ Work Phone_____

Address_____ Cell Phone_____

City_____ State_____ Zip Code_____

Would you rather a confirmation call or email?..... Call ☐ Email ☐

May we call you at work regarding appointments?..... YES..... NO

Insurance carrier's current employer _____

Has your dental insurance carrier changed?..... YES..... NO
If so - To whom?_____

Are you a full time college student? _____ College name & address_____

1. Have you seen a physician since your last visit?..... YES..... NO
   If so, Why?_____ Who?_____
2. Have you had prosthetic replacement surgery?..... YES..... NO
   If so, What?_____ Who?_____
3. Are you taking any prescription or non-prescription medication?..... YES..... NO
   If so, What?_____
4. Have you received any injections or blood transfusions in the last 6 months?..... YES..... NO
   If so, What?_____
5. Have you ever been tested for AIDS, mononucleosis or hepatitis?..... YES..... NO
6. During the last 6 months have you had: pneumonia, persistent cough, fatigue, episodes of diarrhea, or burning mouth?..... YES..... NO
7. Have you ever been told you have a heart murmur?..... YES..... NO
8. Do you have diabetes?..... YES..... NO
9. Are you being treated for heart problems or high blood pressure?..... YES..... NO
   If so, What?_____
10. Have you received radiation therapy or chemotherapy in the last 6 months?..... YES..... NO
    If so, Which?, and by Whom?_____
11. Are you pregnant?..... YES..... NO
12. Have you had allergies or adverse reactions to any medication?..... YES..... NO
13. Would you rather have white fillings instead of traditional silver fillings?..... YES..... NO
14. Would you be interested in a custom fit sports guard for anyone playing sports?..... YES..... NO
15. Are you interested in bleaching/whitening your teeth?..... YES..... NO
16. Do you smoke cigarettes or use tobacco products?..... YES..... NO
17. Do you have a pine nut or pine pollen allergy?..... YES..... NO

Signature_____ Date_____