

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 \_\_\_\_\_