PATIENT HISTORY **DATE** _____

PURPOSE OF VISIT _____ APPROX. DATE LAST CHECKUP _____

PATIENT NAME _____ Date of Birth _____

Responsible Party: _____ SS# _____

Address _____ Home Phone # _____

City _____ Zip _____ Driver License # _____

Cell Phone _____ Email _____

Occupation _____ Employer _____ No. of Yrs _____

Employee Address _____ Work Phone # _____

Spouse of Responsible Party _____ Occupation _____ Work Phone # _____

Spouse Employer _____ Employer Address _____

In case of emergency, whom should be notified _____ Phone # _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

Are you a member of a dental insurance plan? Yes _____ No _____

Name of Insurance Co. _____ Group # _____ Phone# _____

INFORMATION ON FAMILY MEMBER THAT CARRIES DENTAL INSURANCE

Name _____ SS# _____ Birthdate _____

Name of 2nd Ins. Co. _____ Group # _____ Phone# _____

INFORMATION ON FAMILY MEMBER THAT CARRIES DENTAL INSURANCE

Name _____ SS# _____ Birthdate _____

DENTAL HISTORY:

The date of your last visit to a dentist was _____ Date of last full-mouth X-Rays _____

Name and address of previous dentist: _____

How do you feel about the appearance of your teeth? _____

Would you like your teeth to be straighter? Yes ____ No ____ Would you like your teeth to be whiter? Yes ____ No ____

Do the following apply to you?

	Yes	No		Yes	No
Fear of dentist	☐	☐	Lump or swelling in mouth	☐	☐
Pain in jaw, face, mouth	☐	☐	Dry mouth	☐	☐
Frequent headaches	☐	☐	Bleeding Gums	☐	☐
Crooked teeth	☐	☐	Jaw joint sounds or pain	☐	☐
Bad breath	☐	☐	Pain when you open wide (or take a big bite)	☐	☐
Teeth sensitive to heat	☐	☐	Clenching or grinding teeth	☐	☐
Teeth sensitive to cold	☐	☐	Food wedging between teeth	☐	☐

NAME (Last, first, Middle)	AGE	PHONE	EMERGENCY PHONE #

PHYSICIAN'S NAME AND PHONE NUMBER:

The answers to the following questions will assist the dentist in evaluating your general health prior to providing your dental treatment.
PLEASE READ CAREFULLY AND ANSWER EACH QUESTION AS ACCURATELY AS POSSIBLE

1. WHAT IS YOUR IMPRESSION OF YOUR PRESENT HEALTH?	2. YEAR LAST MEDICAL PHYSICAL?

3. PLEASE DRAW A CIRCLE AROUND ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT.

Heart Disease or Condition	Rheumatic Fever	Asthma	Hepatitis	Venereal Disease (Syphilis, Gonorrhea)
Angina Pectoris	Stroke	Hay Fever	Thyroid Disease	
Frequent Chest Pains	Hemophilia	Emphysema	Glaucoma	Drug Addiction
High Blood Pressure	Bruise Easily	Tuberculosis (TB)	Epilepsy or Seizures	Psychiatric Treatment
Shortness of Breath	Prolonged or Unusual Bleeding	Diabetes	Fainting or Dizzy Spells	Cancer
Swollen Ankles	Anemia	Ulcers	AIDS or AIDS Related Complex	Radiation Therapy
Artificial Heart Valve	Blood Transfusion	Kidney Trouble	HIV Positive	Chemotherapy
Congenital Heart Disease	Sickle Cell Disease	Liver Disease	Cold Sores	Inplant Prosthesis
Heart Murmur	Arthritis	Jaundice (Other than at Birth)	Genital Herpes	Unexplained Weight Loss

CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS. ***(IF IN DOUBT, CIRCLE YES)***
(If YES, please give details)

4 ARE YOU PRESENTLY OR HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN DURING THE PAST YEAR?	YES	NO
5 ARE YOU PRESENTLY TAKING ANY MEDICATION OR DRUGS?	YES	NO
6 ARE YOU ALLERGIC TO ANY MEDICINE OR MATERIALS?	YES	NO
7 HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC ?	YES	NO
8 HAVE YOU EVER EXPERIENCED ANY COMPLICATION OR ILLNESS FOLLOWING DENTAL TREATMENT?	YES	NO
9 DO YOU HAVE ANY DISEASES OR CONDITIONS NOT LISTED ABOVE?	YES	NO
10 HAVE YOU EVER BEEN TOLD YOU WERE NOT ELIGIBLE TO BE A BLOOD DONOR?	YES	NO
11 DO YOU USE TOBACCO? *(If YES, please circle and give frequency)* **SMOKE:** Cigarettes Cigars Pipe **SMOKELESS:** Chewing Tobacco Snuff or "Dip" **FREQUENCY:** _____	YES	NO

12 **WOMEN: ARE YOU PREGNAN**
(If YES, please circle trimester block) **YES** **NO** **TRIMESTER** 1 2 3

PATIENT COMMENTS	SIGNATURE OF PATIENT *(or legal guardian if patient is a minor)*	DATE
	X	X

DENTIST'S COMMENTS

BLOOD PRESSURE	DATE	BLOOD PRESSURE	DATE	BLOOD PRESSURE	DATE	BLOOD PRESSURE	DATE

DENTIST'S SIGNATURE	DATE	REVIEWER	DATE	REVIEWER	DATE	REVIEWER	DATE