

**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 .....	<input type="checkbox"/>	<input type="checkbox"/>	Lump or swelling in mouth .....	<input type="checkbox"/>	<input type="checkbox"/>
Pain in jaw, face, mouth .....	<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth .....	<input type="checkbox"/>	<input type="checkbox"/>
Frequent headaches .....	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Gums .....	<input type="checkbox"/>	<input type="checkbox"/>
Crooked teeth .....	<input type="checkbox"/>	<input type="checkbox"/>	Jaw joint sounds or pain .....	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath .....	<input type="checkbox"/>	<input type="checkbox"/>	Pain when you open wide (or take a big bite) .	<input type="checkbox"/>	<input type="checkbox"/>
Teeth sensitive to heat .....	<input type="checkbox"/>	<input type="checkbox"/>	Clenching or grinding teeth .....	<input type="checkbox"/>	<input type="checkbox"/>
Teeth sensitive to cold .....	<input type="checkbox"/>	<input type="checkbox"/>	Food wedging between teeth .....	<input type="checkbox"/>	<input type="checkbox"/>

<b>NAME (Last, first, Middle)</b>	<b>AGE</b>	<b>PHONE</b>	<b>EMERGENCY PHONE #</b>
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**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**

<b>1. WHAT IS YOUR IMPRESSION OF YOUR PRESENT HEALTH?</b>	<b>2. YEAR LAST MEDICAL PHYSICAL?</b>
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**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
Angina Pectoris	Stroke	Hay Fever	Thyroid Disease
Frequent Chest Pains	Hemophilia	Emphysema	Glaucoma
High Blood Pressure	Bruise Easily	Tuberculosis (TB)	Epilepsy or Seizures
Shortness of Breath	Prolonged or Unusual Bleeding	Diabetes	Fainting or Dizzy Spells
Swollen Ankles	Anemia	Ulcers	AIDS or AIDS Related Complex
Artificial Heart Valve	Blood Transfusion	Kidney Trouble	HIV Positive
Congenital Heart Disease	Sickle Cell Disease	Liver Disease	Cold Sores
Heart Murmur	Arthritis	Jaundice (Other than at Birth)	Genital Herpes
			Veneral Disease (Syphilis, Gonorrhea)
			Drug Addiction
			Psychiatric Treatment
			Cancer
			Radiation Therapy
			Chemotherapy
			Inplant Prosthesis
			Unexplained Weight Loss

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

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

**12 WOMEN: ARE YOU PREGNANT**  
*(If YES, please circle trimester block)*

<b>YES</b> <b>NO</b>	<b>TRIMESTER</b> <b>1</b> <b>2</b> <b>3</b>
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<b>PATIENT COMMENTS</b>	<b>SIGNATURE OF PATIENT (or legal guardian if patient is a minor)</b> X	<b>DATE</b> X
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**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