

WELCOME and thank you for filling out this form completely. If you have any questions at any time, please ask us. We will be happy to help.

Name _____ Name I prefer to be called _____

Birthdate ____/____/____ SSN ____/____/____ S M W

Home Address: _____ Apt # _____

City _____ State _____ Zip _____

Cell# (____) _____ Email _____ @ _____

Home# (____) _____ Work# (____) _____ x _____

Whom may we thank for referring you? _____

In case of emergency: Name _____ Relation to pt _____

Home # (____) _____ Work # (____) _____ x _____

DENTAL HISTORY

Main reason for your visit today _____

Have you had unpleasant dental experiences in the past? _____ Yes _____ No

Do you now or have you ever experienced jaw joint pain/discomfort? _____ Yes _____ No

Are your teeth sensitive to: _____ hot _____ cold _____ biting

Do you brush daily? _____ Yes _____ No Do you floss daily? _____ Yes _____ No

Do your gums bleed? _____ Yes _____ No Do your gums itch? _____ Yes _____ No

Have you ever been treated for gum disease? _____ Yes _____ No

Do you have any loose teeth? _____ Yes _____ No

Do you still have your wisdom teeth? _____ Yes _____ No

Do you need pre-medication with antibiotics before dental treatment? _____ Yes _____ No

Are you happy with the way your smile looks? _____ Yes _____ No

If not, what would you change? _____

MEDICAL HISTORY

Are you currently under the care of a physician? _____ Yes _____ No

If so, name _____ Office Phone _____

Your current physical health is: _____ Good _____ Fair _____ Poor

Do you smoke or use tobacco in any other form? _____ Yes _____ No

Are you **ALLERGIC TO** any of the following?

- ____ Aspirin ____ Erythromycin ____ Barbiturates ____ Sulfa ____ Penicillin ____ Codeine
- ____ Jewelry ____ Latex/rubber ____ Dental anesthetics (List: _____)
- ____ Other _____

For women: Are you taking birth control pills? _____ Yes _____ No

Are you pregnant? _____ Yes, week # _____ _____ Unsure _____ No

Are you nursing? _____ Yes _____ No

Are you taking HRT (hormone replacement therapy)? _____ Yes _____ No

Are you **TAKING** any of the following?

- ____ Acetaminophen ____ Blood thinners ____ Nitroglycerin ____ Antibiotics
- ____ Blood pressure med ____ Recreational drugs ____ Antidepressants ____ Chemotherapy
- ____ Steroids/cortisone ____ Antihistamines ____ Heart meds ____ Thyroid med
- ____ Aspirin ____ Insulin/diabetic med ____ Tranquilizers ____ Bone density med

(continued on other side)

List the specific prescription and/or over-the-counter medications (including dosage) you are currently taking:

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Frequent/severe headaches | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Frequent canker sores | <input type="checkbox"/> Persistent cough |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation treatments |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Sickle cell |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis A/B/C (circle which) | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Herpes/fever blister | <input type="checkbox"/> Steroid therapy |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Dental anxiety | <input type="checkbox"/> Infective endocarditis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Fainting spells | | |

Please list any serious medical conditions, surgeries and/or hospitalizations that you have had

_____ DATE _____

_____ DATE _____

_____ DATE _____

_____ DATE _____

_____ DATE _____

_____ DATE _____

_____ DATE _____

I affirm that the information I have given today is correct to the best of my knowledge and I understand that this information will be held in the strictest confidence. I understand that it is my responsibility to inform this office of any changes in my medical or dental conditions.

Patient signature _____ Date _____

If minor, parent signature _____ Date _____



We value your time and want to devote our full attention to your needs when we are treating you. So that we can do so, please turn off your cell phone when in the treatment room. If a family member needs to get a hold of you, please provide them with our phone number ahead of time so our receptionist can take a message for you.

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