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)

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

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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