WE ARE PLEASED TO WELCOME YOU AT DENTEX DENTAL. PLEASE TAKE A FEW MINUTES TO FILL OUT THIS FORM AS COMPLETELY AS YOU CAN
If you have any questions we'll be glad to help you.

PATIENT INFORMATION

NAME _____ (LAST) _____ (FIRST) TODAY'S DATE ____/____/____

ADDRESS _____ SS# ____--____--____

CITY _____ STATE _____ ZIP _____ DATE OF BIRTH ____/____/____

CELL PHONE ( ) _____ How did you hear about us? _____

HOME PHONE ( ) _____ E-mail _____

Do you give us permission to confirm your appointments via SMS text messaging and/or E-mail notifications? YES ☐ NO ☐

MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE ( ) _____ DATE OF LAST EXAM ____/____/____

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____ _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use alcohol?	☐	☐
7. Do you use recreational drugs?	☐	☐
8. Are you wearing contact lenses?	☐	☐

9. Are you allergic to or have you had any reaction to the following?

	YES	NO		YES	NO
• Local anesthetics (ex. novocaine)	☐	☐	• Barbiturates	☐	☐
• Penicillin or other antibiotics	☐	☐	• Sedatives	☐	☐
• Sulfa drugs	☐	☐	• Iodine	☐	☐
• Aspirin	☐	☐	• Latex	☐	☐
• Other (please specify) _____				☐	☐

	YES	NO
10. Do you have persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
11. WOMEN ONLY		
• Are you pregnant or think you may be pregnant?	☐	☐
• Are you nursing?	☐	☐
• Are you taking birth control pills?	☐	☐

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO		YES	NO
High blood pressure	☐	☐	Heart Disease	☐	☐	Tuberculosis	☐	☐	AIDS or HIV Infection	☐	☐
Cardiac Pacemaker	☐	☐	Heart attack	☐	☐	Radiation Therapy	☐	☐	Thyroid Problem	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Glaucoma	☐	☐	Hepatitis / Jaundice	☐	☐
Swollen Ankles	☐	☐	Asthma	☐	☐	Recent Weight Loss	☐	☐	Sexually Transmitted Disease	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Liver Disease	☐	☐	Stomach Troubles / Ulcers	☐	☐
Angina	☐	☐	Anemia	☐	☐	Mitral Valve Prolapse	☐	☐	Chest Pains	☐	☐
Low/High Blood Pressure	☐	☐	Emphysema	☐	☐	Respiratory Problems	☐	☐	Joint Replacement or Implant	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Easily winded	☐	☐	Stroke	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Hay Fever / Allergies	☐	☐	Diabetes	☐	☐

Other YES ☐ NO ☐ _____

DENTAL HISTORY

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquid/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Do you have frequent headaches?	☐	☐
7. Do you clench or grind your teeth?	☐	☐
8. Do you bite your lips or cheeks frequently?	☐	☐

	YES	NO
9. Have you had any head, neck or jaw injuries?	☐	☐
10. Have you ever had instructions on the care of your gums?	☐	☐
11. Have you ever had instructions on the correct method of brushing your teeth?	☐	☐
12. Have you had any orthodontic treatment?	☐	☐
13. Have you ever had any difficult extractions in the past?	☐	☐
14. Have you ever had prolonged bleeding following extractions?	☐	☐
15. Have you ever experienced any of the following problems in your jaw:		
• Clicking?	☐	☐
• Pain (joint, ear, side or face)?	☐	☐
• Difficulty in opening or closing?	☐	☐
• Difficulty in chewing?	☐	☐

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered.
I understand that not providing information can be **dangerous** to my health.

SIGNATURE X _____ ____/____/____

PATIENT/PARENT OR GUARDIAN DATE