



PERSONAL & DENTAL HISTORY INFORMATION

Date: _____

Name: _____ Preferred Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Work Phone Number: _____

Cell Phone/Pager: _____ Email Address: _____

Preferred Method of Contact: Home Phone _____ Work Phone _____ Cell Phone _____ Email _____ Text _____

Date of Birth: _____ Social Security #: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact's Phone Number: _____

Other Family Members: _____

Whom may we thank for referring you to our office? _____

DENTAL INSURANCE INFORMATION:

Insured's Name: _____ Social Security Number: _____

Insured's Date of Birth: _____ Group #: _____

Employer: _____ Location: _____

Insurance Company: _____ Claims Address: _____

As a courtesy to our patients with dental insurance, we will file all claims for you.

DENTAL HISTORY

Are you currently experiencing any dental pain? Explain.	YES	NO

Do you feel nervous about having dental treatment completed? Explain.	YES	NO

Have you ever had a bad experience in a dental office? Explain.	YES	NO

Are you aware of grinding or clenching your teeth?	YES	NO
Is it ever difficult to open or close your mouth?	YES	NO
Do you have any loose teeth?	YES	NO
Does food ever get caught in your teeth?	YES	NO
Do you suffer from chronic dry mouth?	YES	NO
Do your gums bleed when you floss or brush your teeth?	YES	NO
Do you often notice a bad taste in your mouth?	YES	NO
Is your breath as fresh as you would like?	YES	NO
Are your teeth as white as you would like?	YES	NO
Are you interested in sedation for your dental work?	YES	NO
Has a dental office taken x-rays within one year?	YES	NO
May we contact this dentist for your current records?	YES	NO
Name of Previous Dentist: _____		
Location: _____		
Phone Number: _____		

Patient's Name (Please Print): _____ Date: _____

MEDICAL HISTORY

1. CIRCLE any of the following which you have had or have at present:

Heart Failure	Emphysema	AIDS
Heart Disease or Attack	Cough	Hepatitis A (infection)
Angina Pectoris	Tuberculosis (TB)	Hepatitis B (serum)
High Blood Pressure	Asthma	Hepatitis C
Heart Murmur	Hay Fever	Yellow Jaundice
Mitral Valve Prolapse	Sinus Trouble	Blood Transfusion
Congenital Heart Lesions	Allergies or Hives	Drug Addiction
Scarlet Fever	Diabetes	Hemophilia
Artificial Heart Valve	Thyroid Disease	Venereal Disease
Heart Pacemaker	X-ray or Cobalt Treatment	Cold Sores
Heart Surgery	Chemotherapy (Cancer, Leukemia)	Genital Herpes
Artificial Joints	Arthritis	Epilepsy or Seizures
Anemia	Rheumatism	Fainting or Dizziness
Rheumatic Fever	Cortisone Medicine	Nervousness
Kidney Trouble	Glaucoma	Psychiatric Treatment
Ulcers	Pain in Jaw Joints	Sickle Cell Disease
Liver Disease	Bruise Easily	Stroke
Sjorgen's Syndrome	Chronic/Migraine Headaches	

2. Have you been a patient in the hospital during the last two years? Explain. YES NO
3. Have you been under the care of a medical doctor during the past two years? Explain. YES NO
4. Are you allergic to (i.e. itching, rash, swelling of hands, feet or eyes) latex, penicillin, aspirin, codeine or any drugs or medications? Explain. YES NO
5. Have you ever had any excessive bleeding requiring special treatment? Explain. YES NO
6. When you climb stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired? YES NO
7. Do your ankles swell during the day? YES NO
8. Do you use more than 2 pillows to sleep? YES NO
9. Have you lost or gained more than 10 pounds in the past year? YES NO
10. Do you ever wake up from sleep short of breath? YES NO
11. Do you suffer from sleep apnea or use a C-Pap machine? YES NO
12. Have you ever been told that you snore? YES NO
13. Are you on a special diet? YES NO
14. Do you use tobacco products? YES NO
15. Do you consume alcohol on a regular basis? YES NO
16. Has your medical doctor ever said you have cancer or a tumor? Explain. YES NO
17. Do you have any disease, condition or problem not listed? Explain. YES NO
18. Women: Are you pregnant now? YES NO
Are you practicing birth control? YES NO
Do you anticipate becoming pregnant? YES NO
Are you nursing? YES NO

Patient's Name (Please Print): _____ Date: _____

- 19. Are you currently taking any PRESCRIPTION medications? YES NO
- 20. Are you currently taking any OVER THE COUNTER medications? YES NO
- 21. Are you currently taking any HERBAL/VITAMIN or MINERAL SUPPLEMENTS? YES NO

List **ALL** medications you take: (including prescription, over-the-counter, herbal/vitamin or mineral supplements)

Name of Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physician: _____

Phone Number: _____

Specialist: _____

Phone Number: _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform the doctor of dentistry at the next appointment without fail.

Date: _____ Staff Signature: _____ Patient Signature: _____

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Date: _____ Patient Signature: _____