

Name _____ Date of Birth _____ SS # _____

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Tel. _____ Work Tel. _____ Cell. _____

Whom should we thank for your Referral _____

A. Are you here for EMERGENCY treatment? Yes No B. Are you in pain? Yes No

C. Are you or have been suffering from dental phobia (anxiety during dental treatment) Yes No

If yes, have you ever been premedicated to alleviate dental treatment anxiety? _____

D. Have you been sedated with nitrous oxide (laughing gas) to alleviate your anxiety during procedures? Yes No

E. Have you ever had a professional tooth whitening or bleaching procedure perfored? Yes No

F. Please list your present oral complaint: _____

G. Do you have a physician (M.D.)? Yes No

H. Do you have a Nutritionist? Yes No

Physician's Name: _____ Phone: _____

Address: _____

I. Date of last dental exam: _____ J. Date of last full mouth X-Rays: _____

K. Date of last medical X-Rays: _____ (Last Chest X-Ray): _____

L. Have you ever had any of the following conditions? Yes No

- | | | | | | |
|--|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| 1. Rheumatic heart disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 21. Thyroid Problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Heart murmur, mitral valve prolapse? | <input type="checkbox"/> | <input type="checkbox"/> | 22. Unexplained weight loss in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Congenital heart disease? | <input type="checkbox"/> | <input type="checkbox"/> | 23. Kidney problem? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Prosthetic heart valve? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Renal dialysis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Angina? | <input type="checkbox"/> | <input type="checkbox"/> | 25. Hepatitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Heart Attack? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Liver disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Irregular heart beat? | <input type="checkbox"/> | <input type="checkbox"/> | 27. HIV Infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Pacemaker? | <input type="checkbox"/> | <input type="checkbox"/> | 28. Veneral disease/syphilis/gonorrhea? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Shortness of breath after mild activity or when you lie down? | <input type="checkbox"/> | <input type="checkbox"/> | 29. Pelvic inflammatory disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. High blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | 30. Tuberculosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Swollen ankles? | <input type="checkbox"/> | <input type="checkbox"/> | 31. Persistent cough? Coughing up blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Asthma: | <input type="checkbox"/> | <input type="checkbox"/> | 32. PPD Positive? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Emphysema or difficulty breathing? | <input type="checkbox"/> | <input type="checkbox"/> | 33. Enlarged lymph nodes/swollen glands? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Seizures or convulsions? | <input type="checkbox"/> | <input type="checkbox"/> | 34. Autoimmune disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Psychiatric treatment? | <input type="checkbox"/> | <input type="checkbox"/> | 35. Lupus Erythematosus? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Radiation therapy/Chemotherapy? | <input type="checkbox"/> | <input type="checkbox"/> | 36. Arthritis? Rheumatism? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Blood disorder or bleeding tendency or frequent bruising? | <input type="checkbox"/> | <input type="checkbox"/> | 37. Prosthetic joint | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Stomach Ulcer? | <input type="checkbox"/> | <input type="checkbox"/> | 38. Do you have any allergies:
Explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> | 39. Women: Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Recent increase in urination or thirst? | <input type="checkbox"/> | <input type="checkbox"/> | 40. Are you taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |

List all medications you are now taking _____

Have you ever had any of the following oral conditions? Yes No

- | | | | | | |
|-----------------------------------|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Burning in the mouth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dry mouth (xerostomia) | <input type="checkbox"/> | <input type="checkbox"/> | Sores in the mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Offensive breath (halitosis)? | <input type="checkbox"/> | <input type="checkbox"/> | Chronic mouth/gum bleeding? | <input type="checkbox"/> | <input type="checkbox"/> |
| Thrush in the mouth (candidiasis) | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any teeth replaced with dental implants? | <input type="checkbox"/> | <input type="checkbox"/> |

I hereby affirm the forgoing information to be correct.

Signature _____ Date _____