All information given on this form is for our records and will be considered confidential. Date _____

Patient's Name_____ Nickname_____ DOB _____

Address_____ City_____ St____ Zip _____

Email_____ Cell #_____ Work #_____ Home # _____

Social Security #_____ Emergency contact (Name/Phone) _____

Employer_____ Occupation _____

Dental Ins. Yes ○ No ○ Ins. Co. _____ Policy/ID # _____

Spouse's Name_____ Spouse's SS#_____ Spouse's DOB _____

Spouse's Employer_____ Spouse's work # _____

General Dentist_____ Physician_____ Number _____

Referring Dentist_____

PATIENT MEDICAL HISTORY

Have you ever had:	(✓) Yes	No
Heart Trouble	○	○
Heart Murmur	○	○
Rheumatic Fever	○	○
High Blood Pressure	○	○
Shortness of Breath	○	○
Chest Pains	○	○
Drug Reaction	○	○
Allergies: aspirin, penicillin, codeine	○	○
Allergy to Dental Anesthetic	○	○
Diabetes	○	○
Epilepsy	○	○
Tuberculosis	○	○
Glaucoma	○	○
Thyroid or Parathyroid Disorder	○	○
Ulcers or Stomach Trouble	○	○
Cancer	○	○
Radiation or Chemotherapy	○	○
General Surgery	○	○
Joint Replacement Surgery	○	○
Kidney Disease	○	○
Liver Disease	○	○
Hepatitis	○	○
If yes, are you a hepatitis carrier	○	○
Any serious illness not listed?	○	○

Are you:	(✓) Yes	No
Presently under the care of a physician?	○	○
Are you taking any blood thinners?	○	○
Date of last physical exam	○	○
Aware of recent weight change?	○	○
Subject to frequent urination?	○	○
Often thirsty?	○	○
Often exhausted or fatigued?	○	○
Subject to frequent headaches?	○	○
Excessively nervous?	○	○
In good health now?	○	○
Do you smoke?	○	○
How Much?		
Do you presently have, or have you been treated for, drug or alcohol addiction?	○	○
Does anyone in your family have diabetes?	○	○
Have you ever tested positive for HIV?	○	○
Do you have prolonged bleeding after injury or tooth extraction?	○	○
If female, are you now:		
Pregnant?	○	○
Taking anti-pregnancy drug?	○	○
Presently in menopause?	○	○
Post menopause?	○	○

DENTAL HISTORY

Date of last dental visit .....

How often do you have a professional cleaning? .....

How often do you brush? .....

Do you use a hard, medium or soft toothbrush? .....

	(✓) Yes	No
Do you use floss?	○	○
Have you had treatment for Periodontal Disease previously?	○	○
Have you had Orthodontic Treatment (braces)?	○	○
Do you have:		
Bleeding gums	○	○
Loose or shifting teeth	○	○
Changing space between teeth	○	○
Receeding gums	○	○
Sensitive teeth	○	○
Halitosis (bad breath)	○	○
Habit of clenching or grinding teeth	○	○

List all current medications _____

Reason for your visit today _____

_____

Financial Insurance Policy: We accept cash, check, all major credit cards and Card Credit. Should treatment be necessary, we will be happy to file your dental claim. We accept assignment of insurance benefits; however, regardless of insurance coverage we reserve the right to collect any or all fees at the time services are rendered.

Signature_____ Date_____