



Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_  
 Parent name (if under 18): \_\_\_\_\_ Parent phone: \_\_\_\_\_  
 Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Billing address (if different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_ Driver's license #/state: \_\_\_\_\_  
 SS #: \_\_\_\_\_ Employer/Occupation: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_  
 Spouse's name & phone #: \_\_\_\_\_ Emergency phone # (other than spouse): \_\_\_\_\_  
 Primary dental insurance: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Name of insured: \_\_\_\_\_ Relation to patient:  Self  Spouse  Parent  Other  
 Date of birth: \_\_\_\_\_ SS #: \_\_\_\_\_  
 Secondary dental insurance: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Name of insured: \_\_\_\_\_ Relation to patient:  Self  Spouse  Parent  Other  
 Date of birth: \_\_\_\_\_ SS #: \_\_\_\_\_  
 Name of your medical doctor: \_\_\_\_\_ Date of last visit to medical doctor: \_\_\_\_\_  
 Name of previous dentist: \_\_\_\_\_ Date of last visit to dentist: \_\_\_\_\_  
 Referred to us by: \_\_\_\_\_

**DENTAL HEALTH HISTORY**

	YES	NO		YES	NO
Are you apprehensive about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Does your jaw make noise so that it bothers you or others?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had problems with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your jaws often?	<input type="checkbox"/>	<input type="checkbox"/>
Do you gag easily?	<input type="checkbox"/>	<input type="checkbox"/>	Do your jaws ever feel tired?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures?	<input type="checkbox"/>	<input type="checkbox"/>	Does your jaw get stuck so that you can't open freely?	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Does it hurt when you chew or open wide to take a bite?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty in chewing your food?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or pain in front of the ears?	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew on only one side of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any jaw symptoms or headaches upon waking in the morning?	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid brushing any part of your mouth because of pain?	<input type="checkbox"/>	<input type="checkbox"/>	Does jaw pain or discomfort affect sleep, appetite, or daily activities?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>	Do you find jaw pain or discomfort frustrating or depressing?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you floss?	<input type="checkbox"/>	<input type="checkbox"/>	Do you take medicine for pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums feel swollen or tender?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain in the face, cheeks, jaw, joints, throat, or temples?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever noticed slow-healing sores in or around your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Are you unable to open your mouth as far as you want?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive?	<input type="checkbox"/>	<input type="checkbox"/>	Are you aware of an uncomfortable bite?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel twinges of pain when your teeth come in contact with:			Have you had a blow/trauma to the jaw?	<input type="checkbox"/>	<input type="checkbox"/>
Hot foods or liquids?	<input type="checkbox"/>	<input type="checkbox"/>	Are you a habitual gum chewer or pipe smoker?	<input type="checkbox"/>	<input type="checkbox"/>
Cold foods or liquids?	<input type="checkbox"/>	<input type="checkbox"/>			
Sours?	<input type="checkbox"/>	<input type="checkbox"/>			
Sweets?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you take fluoride supplements?	<input type="checkbox"/>	<input type="checkbox"/>			
Are you dissatisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you prefer to save your teeth?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you want complete dental care?	<input type="checkbox"/>	<input type="checkbox"/>			
How often do you brush? _____					
How often do you floss? _____					

**MEDICAL HEALTH HISTORY:**

**Do you have, or have you had any of the following?**

<b>YES</b>	<b>NO</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	Blood pressure problems
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur
<input type="checkbox"/>	<input type="checkbox"/>	Valve problem/MVP
<input type="checkbox"/>	<input type="checkbox"/>	Taking heart medication
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valve
<input type="checkbox"/>	<input type="checkbox"/>	Blood problems
<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising
<input type="checkbox"/>	<input type="checkbox"/>	Frequent nosebleeds
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Blood disease (anemia, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Ever required a blood transfusion?
<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Allergy to latex
<input type="checkbox"/>	<input type="checkbox"/>	Allergy to local anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	Hay fever
<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems
<input type="checkbox"/>	<input type="checkbox"/>	Skin rashes
<input type="checkbox"/>	<input type="checkbox"/>	Taking allergy medication
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Problems
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Weight gain or loss
<input type="checkbox"/>	<input type="checkbox"/>	Special diet
<input type="checkbox"/>	<input type="checkbox"/>	Constipation/Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Kidney or bladder problems
<input type="checkbox"/>	<input type="checkbox"/>	Bone or joint problems
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Back or neck pain
<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement (e.g. hip, pins, implants)?
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells, Seizures, or Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Stroke(s)
<input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe headaches
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems
<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough or swollen glands
<input type="checkbox"/>	<input type="checkbox"/>	<b>Premedication required by physician?</b>

What **pre-med?** \_\_\_\_\_  
 Why taken? \_\_\_\_\_

**Are you allergic, or have you reacted adversely to any of the following?**

<b>YES</b>	<b>NO</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Local anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other antibiotics
<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs
<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates, sedatives, or sleeping pills
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin, Acetaminophen, or Ibuprofen
<input type="checkbox"/>	<input type="checkbox"/>	Codeine, Demerol, or other narcotics
<input type="checkbox"/>	<input type="checkbox"/>	Reaction to metals
<input type="checkbox"/>	<input type="checkbox"/>	Latex or rubber dam
Other: _____		

**PLEASE LIST ALL CURRENT MEDICATIONS:** \_\_\_\_\_

Please list current medical doctors: \_\_\_\_\_

Patient/Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Dentist Signature: \_\_\_\_\_

**Updated:** Patient/Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Dentist Signature: \_\_\_\_\_

<b>YES</b>	<b>NO</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor Treatment? _____ Date of tx: _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Urinate more than 6 times/day?
<input type="checkbox"/>	<input type="checkbox"/>	Thirsty or mouth is often dry?
<input type="checkbox"/>	<input type="checkbox"/>	Family history of diabetes?
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis or other respiratory disease? If so, what? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol? If so, how often? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco products? If so, what type and how much? _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, Jaundice, or Liver Trouble? If so, explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Herpes or other STD
<input type="checkbox"/>	<input type="checkbox"/>	HIV-positive/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Do you wear contact lenses?
<input type="checkbox"/>	<input type="checkbox"/>	History of head injury?
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or other neurological disease?
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric or anxiety disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<b>Sleep Apnea?</b> Do you wear a CPAP? _____ Any problems with it? _____
<input type="checkbox"/>	<input type="checkbox"/>	History of drug or alcohol abuse?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any disease, condition, or problem not listed that you feel we should know about? If so, please describe: _____

**During the past 12 months, have you taken any of the following?**

<b>YES</b>	<b>NO</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics or sulfa drugs
<input type="checkbox"/>	<input type="checkbox"/>	Anticoagulants (e.g. Coumadin)
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure medicine
<input type="checkbox"/>	<input type="checkbox"/>	Insulin, or similar drug
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	Digitalis or drugs for heart trouble
<input type="checkbox"/>	<input type="checkbox"/>	Nitroglycerin
<input type="checkbox"/>	<input type="checkbox"/>	Cortisone (steroids)
<input type="checkbox"/>	<input type="checkbox"/>	Nonprescription drugs/supplements
Other: _____		

**Women:**

<b>YES</b>	<b>NO</b>	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Are you pregnant?</b> Expected delivery date? _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Are you nursing?</b>

**Preferred Pharmacy:** \_\_\_\_\_