Welcome

Patient Information (Please Print)

Today's Date		Date of Birth	Age

Name First Middle Last Preferred Name	Home Phone

Mailing Address	City	State	Zip

Email Address	Cell Phone

Are you: Minor Single Married Separated Divorced Widowed	Male Female

Do you prefer to receive calls at: Home Work Either	Social Security Number	Do You Have Dental Insurance? Yes No

Patient's Employer	City	Work Phone

Spouse/Partner's Name	Employer	Work Phone

If Patient is a Student - Name of School or College	City	State

If Patient is a Student - Father's Name	Mother's Name

Responsible Party

Person responsible for this account

Relationship to Patient	Home Phone

Mailing Address	City	State	Zip

Name of Employer	City	Work Phone

Emergency Notification

Name ____________________ **Relationship** ____________________

Address ____________________ **City, State** ____________________

Phone ____________________

It is important that we know about your dental and medical history. Many things have a direct bearing on your dental health. We will review the questionnaire and discuss it with you in detail. Information you give us is strictly confidential and will not be released to anyone without your written permission.

Dental History

Former Dentist	Date of Last Visit

How often do you brush	How often do you floss

Please check any of the following conditions that apply to you:

___ Use of Tobacco Products

___Bad breath

___Bleeding gums

___Braces (Date ___________________)

___Broken fillings

___Chewing on things

___Clicking/popping jaw

___Grinding/clenching teeth

___Loose teeth

___Periodontal treatment

___Sores or growths in your mouth

___Sucking of Thumb/Finger

Sensitivity to:

___ Hot

___Cold

___Sweets

___Pressure when chewing

OVER →

PHYSICIAN'S NAME ______________________________ **DATE OF LAST PHYSICAL EXAM:** ______________________

Do you have or have you had any of the following. Please indicate with a check mark.
(Please explain all "yes" answers below.)

___Heart disease	___Blood transfusions	___Drug/Alcohol Addiction	___Liver Disease
___Heart attack	When___________	___Emphysema	___Malignancies
___Stroke	___Allergies to anesthetics	___Mitral Valve Prolapse	___Psychiatric care
___High blood pressure	___Allergies to ________________	___Heart Murmur	___Hay Fever
___Low blood pressure	___Anemia	___Epilepsy or Seizures	___Sinus problems
___Circulatory problems	___Osteoporosis	___Fever Blisters	___Thyroid disease
___Nervous problems	___Arthritis	___Glaucoma	___Tonsillitis
___Radiation treatments	___Artificial Joints	___Hemophilia	___Tuberculosis
___Excessive bleeding	___Asthma	___Hepatitis (A, B, or C)	___Ulcer
___AIDS	___Cosmetic Surgery	___Herpes	
___HIV positive	___Diabetes	___Kidney trouble	

Other____

Are you pregnant? ___________________
Are you taking birth control pills? _______

Have you been told to premedicate for dental procedures due to health situations? ______

ARE YOU ALLERGIC TO OR HAVE YOU ADVERSELY REACTED TO ANY OF THE FOLLOWING?

___Aspirin	___Local Anesthetic	___Erythromycin	___Latex
___Nitrous Oxide	___Codeine	___Penicillin	___Other

Please describe any current medical treatment, impending operations, or other medical or dental information that may possibly affect you treatment. Please list any medication that you are currently taking (including aspirin, over-the-counter medications or if you have ever taken Fossamax, Boniva, Actonel or any other Bisphosphonate derivatives).

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Patient Signature:____