PATIENT INFORMATION

First Name: _____ MI: _____ Last: _____ Nick Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

DOB: _____ Male _____ Female _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____

State ID/Drivers License #: _____ E-mail Address: _____

Name of Physician: _____ Physician Phone: _____

In Case of Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about this office? _____

Patient Health History

Do you have a history of:

	Yes	No
A.I.D.S/HIV Positive	❑	❑
Alcoholism	❑	❑
Allergies	❑	❑
Anemia	❑	❑
Arthritis	❑	❑
Asthma	❑	❑
Blood Disease	❑	❑
Bone Disease	❑	❑
Cancer	❑	❑
Chemical Dependency	❑	❑
Chest Pain	❑	❑
Circulatory Problems	❑	❑
Convulsions/Seizures	❑	❑
Diabetes	❑	❑
Excessive Bleeding	❑	❑
Epilepsy	❑	❑
Glaucoma	❑	❑
Hay Fever	❑	❑
Head Injuries	❑	❑
Hearing Impaired	❑	❑
Heart Disease	❑	❑
Heart Valve, Murmur	❑	❑
Pre-Med _____		
Date _____		
Hepatitis/Liver Disease	❑	❑
Type(s) _____		
Hepatitis Carrier	❑	❑
High Blood Pressure	❑	❑
Hip or Joint Replacement	❑	❑
Pre-Med _____		
Date _____		
HPV	❑	❑
Jaundice	❑	❑
Kidney Disease	❑	❑
Kidney Dialysis	❑	❑
Latex Sensitivity	❑	❑
Lupus	❑	❑
Low Blood Pressure	❑	❑
Malignancies	❑	❑
Mitral Valve Prolapse	❑	❑
Neck & Back Problems	❑	❑
Nervous Problems/Disorders	❑	❑
Pacemaker	❑	❑
Prosthetic Joints	❑	❑
Pre-Med _____		
Date _____		
Psychiatric Care	❑	❑
Radiation Treatment	❑	❑
Respiratory Problems/Disorders	❑	❑
Rheumatic Fever	❑	❑
Rheumatism	❑	❑
Scarlet Fever	❑	❑
Seizures/Fainting spells	❑	❑
Sinus Problems	❑	❑
Stomach Ulcers	❑	❑
Stroke	❑	❑
Thyroid Disease	❑	❑
Tuberculosis	❑	❑
Tumors or Growths	❑	❑
Ulcers	❑	❑
Venereal Disease	❑	❑

Medical Questions

List any medications you are taking including non prescription drugs:

_____

_____

_____

_____

Are you allergic to any medications? ❑ Yes ❑ No If yes, please list below:

_____

Are you in good health? ❑ Yes ❑ No

Date of last medical exam: _____

Have you ever been hospitalized? ❑ Yes ❑ No If yes, what was the problem

_____

_____

Do you have any disease/problem you think we should know about? ❑ Yes ❑ No

_____

_____

_____

_____

Have you had a transplant operation that has depressed your immune system?

❑ Yes ❑ No If yes, please provide date _____

Have you had an allergic reaction to Bananas? ❑ Yes ❑ No

Do you smoke or chew tobacco? ❑ Yes ❑ No

Have you had Heart Surgery? ❑ Yes ❑ No

Are you now under the care of an MD? ❑ Yes ❑ No

Are you taking or have you ever taken bishosphonates?
(Forsamax or Actonel for osteoporosis, chemotherapy, etc.) ❑ Yes ❑ No

FOR WOMEN ONLY:

Are you taking birth control pills? ❑ Yes ❑ No

Are you nursing/breast feeding? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No

Expected delivery date: _____

Is there a possibility of pregnancy? ❑ Yes ❑ No

NOTE: Antibiotics (such as penicillin) may alter the affect of birth control pills. Consult your physician/gynecologist for assistance regarding addition methods of birth control.

Dental History Information

Date of dental visit? _____

Name of your previous dentist _____

Reason for today's visit? _____

Have you ever had an oral cancer screening ❑ Yes ❑ No

How often do you floss your teeth? _____

Do your gums bleed when you brush? ❑ Yes ❑ No

Have you or a family member ever been treated for periodontal disease? ❑ Yes ❑ No

Have you ever had complications from an extraction? ❑ Yes ❑ No

Have you ever had a popping or clicking near your ear when you chew? ❑ Yes ❑ No

Are you prone to frequent headaches? ❑ Yes ❑ No

Do you grind or clench your teeth? ❑ Yes ❑ No

Do you have sores, blisters or swelling on your gums, lips or cheeks? ❑ Yes ❑ No

Have you ever had orthodontic treatment? ❑ Yes ❑ No

Do you snore? ❑ Yes ❑ No

Do you have problems with bad breath? ❑ Yes ❑ No

Have you ever had an allergic reaction to a crown, metal filling or dental appliance? ❑ Yes ❑ No

Have you ever used an electric tooth brush? ❑ Yes ❑ No

Are your teeth sensitive to hot, cold or pressure? ❑ Yes ❑ No

On a scale from 1 to 10 with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

If you could change something about your smile what would it be?

- ❑ Whiter
- ❑ Straighter
- ❑ Close Space
- ❑ Replace black mercury filling with tooth colored restorations
- ❑ Repair chipped teeth
- ❑ Replace missing teeth
- ❑ Less gum showing
- ❑ Replace old crowns or caps that don't match

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Patient: _____ Date: _____

Parent/Guardian *(if patient is a minor)* _____ Date: _____

Reviewed by: _____ Date: _____ Dr.. Signature: _____ Date: _____