

Patient Information

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 changes in your health, please tell us. If you have questions, don't hesitate to ask.

Patient Name: _____ Date of Birth: _____ Sex: _____ Age: _____

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

Home Phone: _____ Cell: _____ E-mail: _____

SS#: _____ Employer: _____ Work Phone: _____

Spouse's Name: _____ Emergency Contact (Other Than Spouse): _____

Spouse's Phone: _____ Emergency Contact Phone: _____

Primary Dental Insurance: _____ Primary Ins. Group #: _____

Secondary Dental Insurance: _____ Secondary Ins. Group #: _____

Subscriber's Name: _____ Subscriber's DOB: _____ Subscriber's SS#: _____

Name of Medical Doctor: _____ Date of last visit to Medical Doctor: _____

Name of Previous Dentist: _____ Date of last visit to Dentist: _____

Referred to our Office By: _____

DENTAL HEALTH HISTORY

	Yes	No		Yes	No
Are you apprehensive about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	How often do you brush?		
Have you had problems with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	How often do you floss?		
Do you gag easily?	<input type="checkbox"/>	<input type="checkbox"/>	Do you prefer to save your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures?	<input type="checkbox"/>	<input type="checkbox"/>	Do you want complete dental care?	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Does your jaw make noise that bothers you or others?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty chewing your food?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your jaws frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew on one side of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Do your jaws ever feel tired?	<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 your jaw ever get stuck so that you can't open your mouth freely?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed easily?	<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 your gums bleed when you floss?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or pain in the front of your ears?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums feel swollen or tender?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any jaw symptoms or headaches when you wake in the morning?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever noticed slow healing sores in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Does jaw pain or discomfort affect your appetite, sleep or daily routine?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive?	<input type="checkbox"/>	<input type="checkbox"/>	Do you find jaw pain or discomfort extremely frustrating or depressing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel twinges of pain when your teeth come in contact with:			Do you take medication or pills for pain or discomfort? Such as:		
Hot Foods/Liquids?	<input type="checkbox"/>	<input type="checkbox"/>	Pain Relievers, Muscle Relaxants or Antidepressants?	<input type="checkbox"/>	<input type="checkbox"/>
Cold Foods/Liquids?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a temporomandibular (jaw) disorder (TMD)?	<input type="checkbox"/>	<input type="checkbox"/>
Sour Foods/Liquids?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain in the face, cheeks, jaws, joints, throat or temples?	<input type="checkbox"/>	<input type="checkbox"/>
Sweet Foods/Liquids?	<input type="checkbox"/>	<input type="checkbox"/>	Are you unable to open your mouth as far as you want?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take fluoride supplements?	<input type="checkbox"/>	<input type="checkbox"/>	Are you aware of an uncomfortable bite?	<input type="checkbox"/>	<input type="checkbox"/>
Are you dissatisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a blow to the jaw (trauma)?	<input type="checkbox"/>	<input type="checkbox"/>
			Are you a habitual gum chewer or pipe smoker?	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HEALTH HISTORY

Do you have or have you ever had the following?

	Yes	No
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 problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve problem _____	<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) _____	<input type="checkbox"/>	<input type="checkbox"/>
Ever require a blood transfusion? _____	<input type="checkbox"/>	<input type="checkbox"/>
Allergy Problems _____	<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 _____	<input type="checkbox"/>	<input type="checkbox"/>
(ex. total hip, pins or implants)		

Are you allergic, or have you reacted adversely to the following?	Y	N
Local anesthetics (eg. Novocaine)	<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	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

	Yes	No
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"/>
Pre-medications Required by a Physician _____	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumor _____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Urinate more than 6 times a day _____	<input type="checkbox"/>	<input type="checkbox"/>
Thirsty OR mouth is dry much of the time _____	<input type="checkbox"/>	<input type="checkbox"/>
Family history of diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis OR other respiratory disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, jaundice OR liver trouble _____	<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"/>
History of drug OR alcohol abuse _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any disease, condition OR problem not listed previously that you feel we should know about? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, please describe: _____		

During the past 12 months, have you taken any of the following?	Y	N
Antibiotics or sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants (eg. Coumadin)	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure medication	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>
Insulin, Orinase 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"/>
Natural remedies	<input type="checkbox"/>	<input type="checkbox"/>
Nonprescription drug or supplements	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Women	Y	N
Are you taking contraceptives OR other hormones?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant? If yes, expected delivery date _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Have you reached menopause?	<input type="checkbox"/>	<input type="checkbox"/>
If so, do you have any symptoms? _____		

Patient/Parent Signature: _____

Date: _____ Dentist Initial: _____