

Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

PATIENT INFORMATION *Answers to all Questions are for Office Use and Strictly Confidential*

Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ Zip Code _____

Sex: M F Birthdate ____/____/____ SS Number _____ Marital Status: S M W D

Email Address _____ Can We Contact You With This Address: Yes No

Occupation _____ Employed By _____

Business Address _____ Business Phone _____

Previous General Dentist (Name, Address & Phone Number) _____

How Did You Hear About Our Office Friends / Co-Worker Family Website / Internet Phone Book Location Other _____

Emergency Contact Name _____ Relation To You _____ Phone _____

SPOUSE'S INFORMATION

Name _____ Home Phone _____ Cell Phone _____

Sex: M F Birthdate ____/____/____ SS Number _____

Occupation _____ Employed By _____

Business Address _____ Business Phone _____

INSURANCE INFORMATION

Primary Dental Insurance Company _____ Address _____

Insured's Name _____ Birthdate ____/____/____

Insurance ID Number _____ Subscriber _____ Group Number _____

Secondary Dental Insurance Company _____ Address _____

Insured's Name _____ Birthdate ____/____/____

Insurance ID Number _____ Subscriber _____ Group Number _____

MEDICAL HISTORY

1. Are You Under A Physicians Care Now? Yes No If Yes, Explain _____
2. Have You Ever Been Hospitalized or Had A Major Operation? Yes No If Yes, Explain _____
3. Have You Ever Had A Serious Head or Neck Injury? Yes No If Yes, Explain _____
4. Are You Taking Any Medications, Drugs or Supplements? Yes No If Yes, List _____
5. Do You Take, or Have You Taken, Phen-fen or Redux? Yes No If Yes, Explain _____
6. Have You Ever Taken Any Medication Containing Bisphosphonates? Yes No If Yes, List _____
7. Are You On A Special Diet? Yes No If Yes, Explain _____
8. Do You Use Tobacco? Yes No If Yes, Explain _____
9. Do You Use Controlled Substances? Yes No If Yes, Explain _____

10. Are You Allergic To Any Of The Following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics

Other If Other Please List: _____

MEDICAL HISTORY (Continued From Previous Page)

If You Are A Woman Are You Pregnant or Trying To Get Pregnant Are You Nursing Are You Taking Oral Contraceptives

MARK AN X IN THE BOX IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS / HIV Positive | <input type="checkbox"/> Cold Sores / Fever Blisters | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Attack / Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach / Intestinal Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis / Gout | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Trouble / Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pain In Jaw Joints | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Herpes | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Fainting Spells / Dizziness | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever | |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles | |

Have You Ever Had A Serious Illness Not Listed? Yes No If Yes, List _____

DENTAL HISTORY

- Do You Have A Specific Dental Problem? Yes No If Yes, Explain _____
- Do You Have Dental Examinations On A Routine Basis? Yes No How Often _____
- Would You Describe Your Present Dental Health As Good? Yes No Comments _____
- Do You Feel Nervous About Having Dental Treatment? Yes No If Yes, Explain _____
- Have You Ever Had A Bad Experience In A Dental Office? Yes No If Yes, Explain _____
- Do You Want To Keep Your Remaining Teeth? Yes No If No, Explain _____
- Do You Like Your Smile? Yes No If No, Explain _____
- Have You Had A Reaction To Dental Anesthetic? Yes No If Yes, Explain _____
- Do You Need To Be Pre-Medicated For Dental Treatment? Yes No If Yes, Explain _____
- Is There Anything You Would Like To Bring To Our Attention? Yes No If Yes, Explain _____
- Do You Wish To Talk To The Doctor Privately? Yes No
- How Often Do You Brush? _____ Floss? _____ Use Mouthwash? _____
- What Has Been Used For Comfort In Previous Dental Treatment? Local Anesthetic N₂O Gas Neither

MARK AN X IN THE BOX IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Active Decay | <input type="checkbox"/> Tooth Straightening | <input type="checkbox"/> Dentures | <input type="checkbox"/> Bruxing or Grinding Teeth |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Root Canal Treatment | <input type="checkbox"/> Hot / Cold Tooth Sensitivity | <input type="checkbox"/> Clicking or Popping In Jaw |
| <input type="checkbox"/> Gum Disease | <input type="checkbox"/> Dental Implants | <input type="checkbox"/> Sensitive To Sweets | <input type="checkbox"/> Discomfort In Jaw Joint (TMJ) |
| <input type="checkbox"/> Orthodontic Treatment | <input type="checkbox"/> Removable Dental Appliances | <input type="checkbox"/> Sensitive When Chewing | <input type="checkbox"/> Food Wedging Between Teeth |

Have You Ever Had Any Other Dental Procedures Not Listed? Yes No If Yes, Explain _____

Please List Any Questions, Comments or Additional Information Which May Assist Us In Providing For Your Care _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X _____ Date _____
Patient Signature (Parent or Guardian)