

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

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Billing address (if different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ 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 #: \_\_\_\_\_

Secondary dental insurance: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_ 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
Are you apprehensive about dental treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had problems with previous dental treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you gag easily? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty in chewing your food? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew on only one side of your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid brushing any part of your mouth because of pain? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed easily? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you floss? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums feel swollen or tender? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever noticed slow-healing sores in or about your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids? _____	<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"/>

	Yes	No
How often do you brush? _____		
How often do you floss? _____		
Does your jaw make noise so that it bothers you or others? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your jaws frequently? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your jaws ever feel tired? _____	<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 it hurt when you chew or open wide to take a bite? _____	<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 have any jaw symptoms or headaches upon awaking in the morning? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities? _____	<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 take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a temporomandibular (jaw) disorder (TMD)? _____	<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"/>
Are you unable to open your mouth as far as you want? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of an uncomfortable bite? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you 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 had, any of 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 (e.g., total hip, pins, or 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>Premedications required by physician</b>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/>

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

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

Notes: \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

	Yes	No
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? _____		
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
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 alcohol or drug 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?		
If so, please describe: _____		

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

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

**Women**

	Yes	No
<b>Are you taking contraceptives or other hormones?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Are you pregnant?</b>	<input type="checkbox"/>	<input type="checkbox"/>
If so, expected delivery date: _____		
<b>Are you nursing?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Have you reached menopause?</b>	<input type="checkbox"/>	<input type="checkbox"/>
If so, do you have any symptoms? _____		

Notes: \_\_\_\_\_

\_\_\_\_\_

Patient/Parent Signature: \_\_\_\_\_

Dentist Initial: \_\_\_\_\_