Date _____

Patient Information

Name (Patient) _____ Birthdate _____

Home Address _____ Social Security # _____

City _____ ST ____ ZIP _____ Email _____

Home Phone: (_____) _____ Mobile Phone: (_____)_____

Marital Status _____ Spouse's Name _____

Employer _____ Employee ID #_____

Work Address _____

City _____ ST ____ ZIP _____ Phone # ( )_____

Occupation _____ Avocations (sports, hobbies) _____

Insurance Information

Person Responsible for Account ❑ **Self, or: Name** _____ **Relation** _____

Insurance Subscriber ❑ Self, or: Name _____ Relation _____

Subscriber Birthdate: _____

Employer _____ Employee ID# _____

Occupation _____ Social Security # _____

Employer Address _____

City _____ ST _____ ZIP _____

Dental Insurance Group Name _____ Group # _____

Dental Insurance Co. _____ Address_____

City _____ ST ____ ZIP _____ Phone # ( )_____ ❑

What can we do for you?

- ❑ Help me keep my teeth for the rest of my life
- ❑ Help me improve my smile.
- ❑ Check my mouth and give me a report.
- ❑ I want to prevent decay and toothaches.
- ❑ I want fresher breath.
- ❑ I want straight teeth.
- ❑ I want whiter teeth.
- ❑ Stop my gums from bleeding.
- ❑ Get me out of pain.
- ❑ Fix the hole in my tooth.
- ❑ Give me some more teeth to chew with.
- ❑ Remove my wisdom teeth.
- ❑ Teach me how to care for my teeth.

Medical History Information

1. Have you been under the care of a medical doctor during the past two years? Y N

   Please Explain: _____

   Physician's Name: _____ Phone: (____) _____

   Address: _____ City: _____ State: _____

2. Are you taking any prescription or over-the-counter drugs currently? Y N

   If yes, please list: _____

3. Do you have an allergic or adverse reaction to any medication or substance? Y N

   If yes, please list: _____

4. Have you been a patient in the hospital during the past five years ? Y N

5. Indicate which of the following you have had, or have, at present.

Heart (surgery, disease, attack)	Y	N	Thyroid Problems	Y	N	Hepatitis A (infectious)	Y	N
Chest Pain (angina)	Y	N	Glaucoma	Y	N	B (serum)	Y	N
Congenital Heart disease	Y	N	Swollen Ankles	Y	N	C	Y	N
Heart Murmur	Y	N	Emphysema	Y	N	Cold Sores/Fever Blisters	Y	N
High Blood Pressure	Y	N	Tuberculosis	Y	N	Hemophilia	Y	N
Mitral Valve Prolapse	Y	N	Asthma	Y	N	Sickle Cell Disease	Y	N
Heart Pacemaker	Y	N	Latex Sensitivity	Y	N	Bruise Easily	Y	N
Stroke	Y	N	Allergies/Hay Fever/Hives	Y	N	Liver Disease	Y	N
Rheumatic Fever	Y	N	Sinus Trouble	Y	N	Neurological Disorders	Y	N
Arthritis/Rheumatism	Y	N	Radiation Therapy	Y	N	Epilepsy or Seizures	Y	N
Cortisone Medicine	Y	N	Chemotherapy	Y	N	Fainting or Dizzy Spells	Y	N
Diet (Special, Restricted)	Y	N	Tumors	Y	N	Psychiatric/Psychological Care	Y	N
Kidney Trouble	Y	N	Sensitive/Allergic to Metals (Jewelry)	Y	N	Knee/Hip Replacement	Y	N
Ulcers	Y	N				GERD	Y	N
Taking Appetite Suppressant(s)	Y	N	Venereal Disease	Y	N	Sleep Apnea	Y	N
Diabetes	Y	N	AIDS or HIV	Y	N			

6. Do you have or have you had any disease, condition, or problem not listed? Y N

   If yes, please explain: _____

7. For Women:

   If you are you pregnant, how many months: _____

   Are you nursing? Y N

   Are you taking birth control pills? Y N

Signature: _____ Date: _____

Print Name _____

Dental History Information

What is the reason for today's visit? _____ Referred By _____

Dates: Last Dental Visit _____ Last Cleaning _____ Last Full-Mouth X-rays_____

What was done at your last dental visit? _____

Previous Dentist's Name _____ City _____ State _____

How often do you brush your teeth?_____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpicks, etc.) _____

• Are any of your teeth sensitive to:

- Hot or cold?	Y	N
- Sweets?	Y	N
- Biting or Chewing?	Y	N
• Have you noticed any mouth odors or bad tastes?	Y	N
• Do you frequently get cold sores, blisters, or any other oral lesions?	Y	N
• Do your gums bleed or hurt?	Y	N
• Has anyone in your family had gum disease or tooth loss?	Y	N
• Have you noticed any loose teeth or change in your bite?	Y	N
• Does food tend to become caught in-between your teeth?	Y	N

If yes, where? _____

• Do you:

• Clench or grind your teeth while awake or asleep?	Y	N
• Bite your lips or cheeks regularly?	Y	N
• Hold foreign objects with your teeth? (e.g., pencils, pipe, pins, nails)	Y	N
• Have tired jaws, especially in the morning?	Y	N
• Smoke tobacco?	Y	N
• Chew tobacco?	Y	N

• Have you ever had:

• Orthodontic treatment?	Y	N
• Oral surgery?	Y	N
• Periodontal (gum) treatment?	Y	N
• Your teeth ground or the bite adjusted?	Y	N
• A bite plate or mouth guard?	Y	N
• A serious injury to the mouth or head?	Y	N

If so, please describe, including cause _____

_____

• Have you experienced:

- Clicking or popping of the jaw?	Y	N
- Pain? (in your jaw, ear, side of face)	Y	N
- Difficulty in opening or closing your mouth?	Y	N
- Difficulty in chewing on either side of your mouth?	Y	N
• Are you satisfied with your teeth's appearance?	Y	N
• Do you expect to eventually lose your teeth and wear artificial dentures?	Y	N
• Do you feel nervous about having dental treatment?	Y	N

If so, what is your biggest concern? _____

_____

• Have you ever had an upsetting dental experience?	Y	N

If yes, please describe: _____

_____

• Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?	Y	N
• Are you deeply concerned about the finances required to return your mouth to excellent dental health?	Y	N

If you could wave a magic wand and magically change your smile to look exactly how you want, what, if anything, would you change?

_____

_____

_____

Please explain anything else about having dental treatment that you would like us to know:

_____

_____

_____