Patient Information

Patient Name: _____ Date: _____
Birthdate: _____ SSN#: _____ Gender: _____ Family Status: _____
Phone: _____ Cell: _____ Work: _____ Ext: _____
EMAIL: _____
Address: _____
_____

Medical History

Physician's Name: _____
Address: _____
Phone #: _____

Are you under the care of a physician? YES ☐ NO ☐

If yes, for what reason?_____
_____

Are you currently taking any medications? YES ☐ NO ☐

List medications both prescribed and over-the-counter taken routinely:

_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES:

Are you allergic to:

☐ Penicillin ☐ Codeine ☐ Local Anesthetic
☐ Aspirin ☐ Other Antibiotics ☐ Latex
☐ Other _____

Do you have, or have you ever had any of the following *(Check all that apply)***:**

☐ Heart Disease/Surgery
☐ Heart Murmur
☐ Pacemaker
☐ Rheumatic Fever
☐ Congenital Heart Disease
☐ Artificial Heart Valve
☐ Mitral Valve Prolapse
☐ Abnormal Blood Pressure
☐ Psychiatric Care
☐ Anorexia
☐ Bulimia
☐ Lung Disease
☐ Tuberculosis
☐ Asthma

☐ Shortness of Breath
☐ Respiratory Ailments
☐ Emphysema
☐ Sinus Trouble
☐ Diabetes
☐ Thyroid Problems
☐ Kidney Problems
☐ Venereal Disease
☐ HIV/AIDS/ARC
☐ Alcohol Addictions
☐ Drug Dependency
☐ Blood Disorders
☐ Anemia
☐ Leukemia

☐ Prolonged Bleeding
☐ Hemophilia
☐ Sickle Cell Disease
☐ Cancer
☐ Tumors
☐ Chemotherapy
☐ Radiation Treatment
☐ Neurological Disorders
☐ Epilepsy
☐ Stroke
☐ Arthritis/Rheumatism
☐ Prosthetic Implants
☐ Artificial Joint
☐ Liver Disease

☐ Hepatitis A/B/C
☐ Ulcers
☐ Stomach Disorders
☐ GERD (gastric reflux)
☐ Hearing Impaired
☐ Glaucoma
☐ Cortisone Medicine
☐ Fainting Spells
☐ Organ Transplant
☐ Removal of Spleen
☐ Osteoporosis
☐ Blood Transfusion

Other_____
_____

Comments:_____
_____
_____
_____

Are you currently pregnant? YES ☐ NO ☐

Do you currently smoke or use tobacco products?_____YES ☐ NO ☐ If yes, which kinds?_____
Have you used tobacco products in the past?_____YES ☐ NO ☐ If yes, how long ago? _____
Have you had any other illness, hospitalizations or accidents? YES ☐ NO ☐
Please explain: _____

Dental History

Reason for this dental visit:_____

Date of last dental visit:_____ Date of last x-rays:_____

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

Do you have any dental concerns? _____

Are any of your teeth sensitive to:

☐ Hot ☐ Biting/Chewing
☐ Cold ☐ Sweets

Do your gums bleed or hurt?_____YES ☐ NO ☐
Have you experienced gum disease?_____YES ☐ NO ☐
Do you have any loose teeth?_____YES ☐ NO ☐

Do you have a tendency to clench or grind your teeth?_____YES ☐ NO ☐
Does your jaw ache or become tense?_____YES ☐ NO ☐
Does your jaw pop or click?_____YES ☐ NO ☐
Do you have difficulty opening or closing your mouth?_____YES ☐ NO ☐

Have you ever had any of the following:

☐ Orthodontic Treatment ☐ Implants
☐ Oral Surgery ☐ Periodontal Treatment
☐ Removable Partial or Denture ☐ Gum Surgery
☐ Serious injury to head or neck ☐ Teeth removed/missing

Do you like the appearance of your smile?_____YES ☐ NO ☐
Do you like the color of your teeth?_____YES ☐ NO ☐
Are your teeth as straight as you would like?_____YES ☐ NO ☐

If there is something you would change about your teeth, what would that be?

_____
_____
_____

Is there anything else you would like addressed during your dental treatment?

_____
_____
_____

Comments:

_____
_____
_____
_____

Whom may we thank for referring you to our practice? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

_____ Date:_____
(Signature of patient or parent/guardian)