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Patient Name: _____ Date Of Birth: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Social Security Number: _____
Minor ___ Single ___ Divorced ___ Seperated ___ Married ___ Widowed ___
Cell Phone Number: _____ Home Phone Number: _____
Email Address: _____
Preferred Method Of Communication: Home ___ Cell ___ Email ___ Text ___
How Would You Like To Receive Your Appointment Reminders: Home ___ Cell ___ Email ___ Text ___
If Patient Is A Minor List Responsible Party: _____
Patients Employer: _____
Spouse Name: _____ Date Of Birth: _____
Spouse Social Security Number: _____
Spouse Employer Name: _____
In Case Of Emergency, Contact: _____
Phone Number: _____ Relationship To Patient: _____
Who May We Thank For Referring You: _____

Do You Have Dental Insurance: Yes / No

Primary Dental Insurance Information:

Name Of Insured: _____ Relationship To Insured: _____
Insured Social Security Number: _____ Insured Birth Date: _____
Name Of Policy Holders Employer: _____
Name Of Insurance Company: _____
Phone Number Of The Insurance: _____
Address Of Insurance Company: _____
Group Number: _____ ID Number: _____

Do You Have A Secondary Insurance: Yes / No

Name Of Insured: _____ Relationship To Insured: _____
Insured Social Security Number: _____ Insured Birth Date: _____
Name Of Policy Holders Employer: _____
Name Of Insurance Company: _____
Phone Number Of The Insurance: _____
Address Of Insurance Company: _____
Group Number: _____ ID Number: _____

Signature: _____ **Today's Date:** _____

Patient Dental & Medical Health History Information

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION			
Last Name:	First Name:	Middle Name:	
Home Phone:	Cell Phone:	Work Phone:	
Email Address:			
Mailing Address:	City:	State:	Zip:
Date of Birth: / /	Gender:		
Occupation:			
Emergency Contact: Name:	Relationship:	Phone:	
If you are completing this form for another person, what is your name and relationship to that person? Name: _____ Relationship: _____			
If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.			
DENTAL HISTORY & SYMPTOMS			
What is the reason for your visit today?			
Are you currently experiencing any dental pain or discomfort? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?			
When was your last dental exam? / /		What was done at that appointment?	
When was the last time you had dental x-rays taken?			
Please mark an "X" in the box ONLY if this applies to you.			
Is it hard to open your mouth? <input type="checkbox"/> Does it hurt to chew, bite or swallow? <input type="checkbox"/> Do your gums bleed when you brush or floss your teeth? <input type="checkbox"/> Have you ever had periodontal (gum) treatments like scaling and root planing? <input type="checkbox"/> Do you have, or have you ever had, any sores or growths in your mouth? <input type="checkbox"/> Do you clench or grind your teeth? <input type="checkbox"/> Does your jaw click, pop or hurt? <input type="checkbox"/> Do you have earaches or neck pains? <input type="checkbox"/> Does dental treatment make you nervous? <input type="checkbox"/> Have you ever experienced any of these sleep-related breathing disorders? <input type="checkbox"/> <input type="checkbox"/> Mouth breathing <input type="checkbox"/> Snoring <input type="checkbox"/> Trouble breathing during sleep	Have you ever had a serious injury to your head or mouth? <input type="checkbox"/> If yes, please describe what happened and when it happened: _____ _____ Have you ever had problems with dental treatment in the past? <input type="checkbox"/> If yes, please describe what happened: _____ _____ Have you ever had a reaction to, or problem with, dental anesthesia? <input type="checkbox"/> If yes, please describe what happened: _____ _____ Are you unhappy with your smile? <input type="checkbox"/> If yes, why? Please mark all that apply: <input type="checkbox"/> The color of your teeth <input type="checkbox"/> The shape of your teeth <input type="checkbox"/> The position of your teeth <input type="checkbox"/> Other. Please describe: _____		
MEDICATIONS & OTHER PRODUCTS/SUBSTANCES			
Please use an "X" to mark your answers to the following questions. Yes No ?			
Are you taking any blood thinners (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
If yes, what medication are you taking? _____			
Are you taking any medication to treat osteoporosis or Paget's disease? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zoledronate (Reclast®), and denosumab (Prolia®).			
If yes, what medication are you taking? _____			
Are you taking, or scheduled to take, an IV medication to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zoledronate (Zometa®).			
If yes, what medication are you taking? _____ How many years have you been taking it? _____			
Are you taking hormonal replacements ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Do you use any form of tobacco or nicotine products (cigarettes, cigars, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Do you use vaping products ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
How many alcoholic beverages do you have per week? _____			
Do you use controlled substances (drugs), including marijuana, for either medicinal or recreational reasons? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
If yes, what substances? _____ If yes, how often is your use? <input type="checkbox"/> Daily <input type="checkbox"/> Several times per week <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally			
Was the substance prescribed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what reason(s)? _____			
Do you take any other prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
If yes, please list them here and include information about how much and how often you use each one. _____			
WOMEN ONLY: Are you:			
Taking birth control pills ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Pregnant? If yes, number of weeks: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Nursing? If yes, number of weeks: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			

ALLERGIES Please use an "X" to mark your answers to the following questions.

Are you allergic to or have you had an allergic reaction to:	Yes	No	?	Yes	No	?	
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasalazine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapson, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Please describe any "Yes" answers and include information about your experience.			
Hay fever/seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Iodine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Latex (rubber)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Metals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / /	What is your normal blood pressure (systolic, diastolic)?
Doctor's Name:	Phone:

Please use an "X" to mark your answers to the following questions.

Question	Yes	No	?
Are you in good physical health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently being seen or treated by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician or previous dentist recommended that you take antibiotics before having dental work done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any type (either total or partial) of joint replacement surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a heart valve replacement or heart surgery ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an organ or bone marrow/stem cell transplant ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you traveled internationally within the last 30 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a fever (100.4°F or above) in the last 72 hours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If you answered yes to any of the above, please explain: _____			

MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?		Yes	No	?	Yes	No	?
Heart (Cardiac) Health					Digestive Health		
Pacemaker/implanted defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>
Artificial (prosthetic) heart valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		G.E. reflux/persistent heartburn (GERD)	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Eye (Vision) Health		
Unrepaired, cyanotic CHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last 6 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Other		
Repaired CHD with residual defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>
Coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes (type I or II)	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Type of infection: _____		
Heart murmur/rhythm disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis, jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Immune deficiency	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
Breathing (Respiratory) Health					Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>
Asthma (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Sexually transmitted infection (STI)	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Cancer		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood (Circulatory) Health		
Type: _____					Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Date of diagnosis: _____					Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy: _____					If yes, date: _____		
Radiation treatment: _____					Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Brain (Neurological)/Mental Health					High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Autoimmune Disease		
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Mental health disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Post-traumatic stress disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Traumatic brain injury or concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Do you have any disease, condition, or problem that's not listed here? If so, please explain. _____

MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.

In the past 30 days, have you:	Yes	No	?	Yes	No	?	Yes	No	?
had pain or tightness in the chest?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	found it hard to catch your breath?	<input type="checkbox"/>	<input type="checkbox"/>	experienced vomiting, diarrhea, chills, night sweats or bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
coughed up blood or had a cough that lasted longer than 3 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	had a high fever (greater than 101.5°F) for no reason?	<input type="checkbox"/>	<input type="checkbox"/>	had migraines or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>
been exposed to anyone with tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	noticed a change in your vision?	<input type="checkbox"/>	<input type="checkbox"/>			
had a rapid or irregular heart beat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	fainted for no reason?	<input type="checkbox"/>	<input type="checkbox"/>			

NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.

I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Office Use Only: Medical Alert Premedication Allergies Anesthesia

Reviewed by: _____ Date: _____