

***Patient Information***

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_

Gender: \_\_\_M \_\_\_F Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_Single \_\_\_Married \_\_\_Divorced \_\_\_Widowed \_\_\_ Minor

E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you to our practice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Responsible Party Information*

Name of person responsible for account: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_

E-Mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Dental History***

Reason for today’s visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Former Dentist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last dental x-rays:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you floss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often do you brush? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check any that apply if you have had problems with any of the following:

 \_\_\_\_ Bad Breath \_\_\_Grinding teeth \_\_\_Sensitivity to hot

 \_\_\_ Bleeding gums \_\_\_Loose or broken teeth \_\_\_Sensitivity to sweets

\_\_\_ Clicking/popping jaw \_\_\_Periodontal treatment \_\_\_ Sensitivity when biting

\_\_\_Food caught between teeth \_\_\_Sensitivity to cold \_\_\_ Sores/growths in the mouth

***Medical History***

Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever used a bisphosphonate medication? Yes No

If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any serious illnesses or operations? Yes No

If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a blood transfusion? Yes No

If yes, please give approximate dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Women) Are you pregnant? Y N Nursing? Y N Taking birth control? Y N

Please circle any of the following that you have had or currently have

\_\_\_Allergies, Seasonal \_\_\_Hepatitis

\_\_\_Anemia \_\_\_Hernia repair

\_\_\_Arthritis, Rheumatism \_\_\_High Blood Pressure

\_\_\_Artificial Heart Valves \_\_\_HIV/AIDS

\_\_\_Artificial Joints, Pins, Etc \_\_\_Jaw Pain

\_\_\_Asthma \_\_\_Kidney Disease

\_\_\_Abnormal Bleeding \_\_\_Liver Disease

\_\_\_Back Problems \_\_\_Mitral Valve Prolapse

\_\_\_Blood Disease \_\_\_Pacemaker

\_\_\_Cancer \_\_\_Radiation Treatment

\_\_\_Chemical Dependency \_\_\_Respiratory Disease

\_\_\_Chemotherapy \_\_\_Rheumatic Fever

\_\_\_Circulatory Problems \_\_\_Scarlet Fever

\_\_\_Congenital Heart Lesions \_\_\_Shortness of Breath

\_\_\_Cortisone Treatments \_\_\_Skin Rash

\_\_\_Persistent Cough \_\_\_Stroke

\_\_\_Cough Up Blood \_\_\_Swelling of feet or ankles

\_\_\_Diabetes \_\_\_Thyroid Problems

\_\_\_Epilepsy Fainting \_\_\_Tobacco Habit

\_\_\_Glaucoma \_\_\_Tonsillitis

\_\_\_Headaches \_\_\_Tuberculosis

\_\_\_Heart Murmur \_\_\_Ulcer

\_\_\_Heart Problems \_\_\_Venereal Disease

\_\_\_Hemophilia \_\_\_High Cholesterol

List all medications you are currently taking \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any allergies you have: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Edgewater Dental – 3425 Highway 6 South, Ste. 108 – Sugar Land, TX 77478 – P: 832.532.7120*