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 #*: ______

SS #*: ______ Employer/Occupation*: ______ Bus. Phone: ______

Emergency phone #*: ______ Spouse's Name and Number: ______

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

What is your primary dental concern?

Are you apprehensive about dental treatment? ______

Have you had problems with previous dental treatment?

Do you wear dentures? ______

Does food catch between your teeth? ______

Do you have difficulty in chewing your food? ______

Do you avoid brushing any part of your mouth because of pain? ______

Do your gums bleed easily? ______

Do your gums feel swollen or tender? ______

Have you ever noticed slow healing sores in or about your mouth? ______

Are your teeth sensitive? ______

Do you have tooth pain to hot, sweet or cold foods? ______

Do you take fluoride supplements? ______

Are you dissatisfied with the appearance of your teeth? _

Are you satisfied with the shape and color of your teeth?

Do you want straighter teeth? ______

Do you have any missing teeth? ______

Do they pose a problem to you visually or functionally? _

Are you interested in replacing them? ______

Yes No

How often do you brush?

How often do you floss?

Have you ever been told you clench or grind your teeth?

Do your jaws ever feel tired? ______

Does your jaw get stuck so that you can't open freely? ___

Does it hurt when you chew or open wide to take a bite?

Do you have any jaw symptoms or headaches upon awaking in the morning? ______

Do you find jaw pain or discomfort extremely frustrating or depressing? ______

Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)? ______

Do you have temporomandibular (jaw) disorder (TMD)? _

Do you have pain in the face, cheeks, jaws, joints, throat, or temples? ______

Are you unable to open your mouth as far as you want? _

Do you find that you are often tired in the morning? ______

Have you ever been told that you snore? ______

MEDICAL HEALTH HISTORY

Do you have, or have you had, any of the following?

	Yes	No
Heart Problems ____________________		
Chest pain ______________________		
Shortness of breath? ___________		
Blood pressure problem __________		
Heart murmur ___________________		
Heart valve problem ____________		
Taking heart medication__________		
Rheumatic fever _______________		
Pacemaker_____________________		
Artificial heart valve ___________		
Blood Problems _____________________		
Easy bruising ___________________		
Abnormal bleeding______________		
Blood disease (anemia) __________		
Ever require a blood transfusion? __		
Asthma? ____________________________		
Intestinal Problems __________________		
Ulcers _______________________		
Weight gain or loss ______________		
Special diet ____________________		
Constipation/Diarrhea ___________		
Kidney or bladder problems_______		
Bone or Joint Problems_______________		
Arthritis _______________________		
Back or neck pain ______________		
Joint replacement______________ (e.g., total hip, pins, or implants)		
Fainting Spells, Seizures, or Epilepsy _____		
Stroke(s) ____________________________		
Frequent or severe headaches__________		
Thyroid problems _____________________		
Persistent cough or swollen glands _______		
Premedication required by physician ____		
Cancer/Tumor ________________________		
Are you taking any medications? _____________		

Please specify:

	Yes	No
Diabetes ______________________________________		
Urinate more than 6 times a day ____________		
Thirsty or mouth is dry much of the time______		
Family hitory of diabetes__________________		
Tuberculosis or other respiratory disease____________		
Do you drink alcohol? ___________________________		
If so, how much?		
Hepatitits, jaundice, or liver trouble _______________		
Herpes or other STD _____________________________		
HIV-positive/AIDS ______________________________		
Glaucoma _____________________________________		
Do you wear contact lenses? ______________________		
History of head injury? ___________________________		
Epilepsy or other neurological disease?_____________		
History of alcohol or drug abuse?_________________		
Do you have any disease or condition not listed? _____		

If so, please describe:

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

	Yes	No
Antibiotics or sulf drugs		
Anticoagulants (e.g. Coumadin)		
High blood pressure medicine		
Tranquilizers		
Insulin, Orinase or similar drug		
Aspirin		
Digitalis or drugs for heart trouble		
Nitroglycerin		
Cortisone (steroids)		
Natural remedies		
Nonprescription drug/supplements		
Other		

Women	Yes	No
Are you taking contraceptives or other hormones?		
Are you pregnant?		
If so, expected delivery date:		
Are you nursing?		
Have you reached menopause?		
If so, do you have any symptoms?		

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

	Yes	No
Local anesthetics ("Novocaine")		
Penicillin or other antibiotics		
Sulfa drugs		
Aspirin, Acetaminophen or Ibuprofen		
Codeine, Demerol		
Reaction to metals		
Latex or rubber dam		
Other		

By signing below I agree that the above information is correct to the best of my knowledge.

Patient Signature (or Parent/Guardian Signature if under 18 years old).

Date