



Patient Information

Title First Name M.I. Last Name Suffix Date:
I prefer to be called Email: _____
Address City State Zip
Home Phone Cell Phone Business Phone Ext.
Preferred Contact # Occupation: Gender Male Female
Date of Birth / / Marital Status Single Married Divorced Widowed Separated
Referred By:
Other family members seen by us:

Emergency Contact

Title First Name M.I. Last Name Suffix
Relationship to Patient
Home Phone Cell Phone Business Phone Ext.

Responsible Party

Who will be responsible for your account? Self Spouse Father Mother Other:

Title First Name M.I. Last Name Suffix
Address City State Zip
Home Phone Business Phone Ext.
Date of Birth / / Occupation:
Employer

Dental Insurance

Insurance Company Name
Company Address City State Zip
Company Phone # Group # (Plan, Local or Policy #) Insured ID# or SSN _____
Insured's Name Relationship to Patient
Insured's Date of Birth / / Insured's Employer _____
Insured's Employer Address

Secondary Insurance

Insurance Company Name: _____
Company Address _____ City _____ State _____ Zip _____
Company Phone # _____ Group # (Plan, Local or Policy #) _____ Insured ID# or SSN _____
Insured's Name _____ Relationship to Patient _____
Insured's Date of Birth / / Insured's Employer _____
Insured's Employer Address _____

Dental Information

When was your last dental visit? What was done?

When were x-rays taken last? When was your last dental cleaning?

Reason for today's visit: Are you in pain? Yes No For how long?

Please rate your current dental health: Excellent Good Fair Poor

How do you feel about your smile?

Are you fearful of dental treatment? Yes No Please explain:

Have you ever had trouble getting numb or had reactions to local anesthetic? Yes No

Please describe:

Do your gums bleed? Yes No

Is your mouth dry? Yes No

Teeth sensitive to heat, cold, sweets, brushing, or flossing? Yes No

Have you noticed any bad tastes or bad breath? Yes No

Have you ever had periodontal (gum) treatments? Yes No

Have you had orthodontic (braces) treatment? Yes No

Have you had any problems associated with previous dental treatment? Yes No

Do you have earaches or neck pains? Yes No

Do you have any clicking, popping or discomfort in the jaw? Yes No

Have you noticed any loose or shifting teeth? Yes No

Do you clench or grind your teeth? Yes No

Have you had headaches on a regular basis in the morning, evening, or after eating? Yes No

Have you had your bite adjusted? Yes No

Do you have sores or ulcers in your mouth? Yes No

Do you wear dentures or partials? Yes No

Have you ever had a serious injury to your head or mouth? Yes No

Health History

Please rate your current physical health: Excellent Good Fair Poor Height: Weight:

Date of last physical exam Are you now under the care of a physician? Yes No

Current Physician

What condition is being treated?

Physician Name Phone Number

Address City State Zip

For Women

Are you pregnant? Yes No How many weeks?

Taking birth control pills or hormonal replacement? Yes No Are you nursing? Yes No

Have you had a serious illness, operation or been hospitalized in the past 5 years? Yes No

What was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Yes No

Please list any medications (prescription or over the counter) you are taking:

Name <input type="text"/>	For what condition? <input type="text"/>	Dosage <input type="text"/>
Name <input type="text"/>	For what condition? <input type="text"/>	Dosage <input type="text"/>
Name <input type="text"/>	For what condition? <input type="text"/>	Dosage <input type="text"/>
Name <input type="text"/>	For what condition? <input type="text"/>	Dosage <input type="text"/>
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Name <input type="text"/>	For what condition? <input type="text"/>	Dosage <input type="text"/>

Has anyone suggested you need antibiotics prior to receiving dental care? Yes No

Reason:

Have you had an orthopedic total joint (hip, knee, elbow, shoulder, finger) replacement? Yes No

Date: _____ Have you had any complications? _____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? Yes No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes No Date treatment began: _____

Do you use controlled substances (drugs)? Yes No

Do you use tobacco (smoking, snuff, chew, bidis)? Yes No Are you interested in quitting? Yes No

Do you drink alcoholic beverages? Yes No How much do you typically drink in a week? _____

Allergies

Are you allergic to or have you had a reaction to:

Local anesthetics Yes No

Details: _____

Aspirin Yes No

Details: _____

Penicillin or other antibiotics Yes No

Details: _____

Barbiturates, sedatives, or sleeping pills Yes No

Details: _____

Sulfa drugs Yes No

Details: _____

Codeine or other narcotics Yes No

Details: _____

Metals Yes No

Details: _____

Latex (rubber) Yes No

Details: _____

Iodine Yes No

Details: _____

Hay fever/seasonal Yes No

Details: _____

Food Yes No

Details: _____

Other _____

Medical Conditions

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

AIDS / HIV Positive Yes No

Drug Addiction Yes No

Low Blood Pressure Yes No

Alzheimer's Disease Yes No

Emphysema Yes No

Lung Disease Yes No

Anaphylaxia Yes No

Epilepsy or Seizures Yes No

Mitral Valve Prolapse Yes No

Anemia Yes No

Excessive Thirst Yes No

Pain in Jaw Joints Yes No

Angina Yes No

Fainting Spells/Dizziness Yes No

Parathyroid Disease Yes No

Arthritis/Gout Yes No

Glaucoma Yes No

Psychiatric Care Yes No

Artificial Heart Valve Yes No

Heart Attack/Failure Yes No

Radiation treatment Yes No

Artificial Joint Yes No

Heart Murmur Yes No

Rheumatic Fever Yes No

Asthma Yes No

Heart Pace Maker Yes No

Scarlet Fever Yes No

Blood Disease Yes No

Heart Trouble/Disease Yes No

Sickle Cell Disease Yes No

Breathing Problems Yes No

Hemophilia Yes No

Sinus Trouble Yes No

Cancer Yes No

Hepatitis A, B or C Yes No

Stomach/Intestinal Disease Yes No

Chest Pains Yes No

High Blood Pressure Yes No

Stroke Yes No

Cold Sores/Fever Blisters Yes No

Irregular Heartbeat Yes No

Thyroid Disease Yes No

Congenital Heart Disorder Yes No

Kidney Problems Yes No

Tuberculosis Yes No

Diabetes Yes No

Leukemia Yes No

Tumors/Growths Yes No

Do you have any disease, condition, or problem not listed above that you think we should know about? Yes No

Please explain: _____

Confirmation

I certify that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient Signature _____