

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ I prefer to be called \_\_\_\_\_

Sex:  Male  Female Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_  
City State Zip

Single  Married  Divorced  Widowed  Separated

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

Work#: \_\_\_\_\_ Employer: \_\_\_\_\_

Email: \_\_\_\_\_

How would you like to be confirmed for your appointment?  Phone  E-mail  Text Message

If text message who is your cell phone provider:

US Cellular  Verizon  Sprint  AT&T  T-Mobile  Other \_\_\_\_\_

Where & when are the best times to reach you? \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

**Spouse Information**

His/Her name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Cell#: (\_\_\_\_) \_\_\_\_\_ SS#: \_\_\_\_\_

**Dental History**

Previous / Present Dentist: \_\_\_\_\_ Date last seen: \_\_\_\_\_

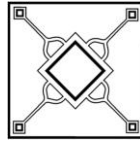
Why have you come to the dentist today? \_\_\_\_\_

Are you currently in pain?  Yes  No

Do your gums ever bleed?  Yes  No

Your current dental health is:  Good  Fair  Poor

Do you like your smile?  Yes  No



Do you have a history of cold sores or fever blisters?  Yes  No

Would you like whiter teeth?  Yes  No    Fresher Breath?  Yes  No

How many times a week do you floss? \_\_\_\_\_ How many times a day do you brush? \_\_\_\_\_

**Allergies**

Are you allergic to any of the following? (please circle)

Aspirin	Erythromycin	Metals
Codeine	Jewelry	Penicillin
Dental Anesthetics	Latex	Tetracycline

Please list any other drugs/materials that you are allergic to: \_\_\_\_\_

Do you have a history of pain/tenderness in the jaw joint (TMJ/TMD)?  Yes  No

Have you ever had difficult extractions?  Yes  No

Have you ever had prolonged bleeding following extractions?  Yes  No

Are there currently any growths or sores in or around your mouth?  Yes  No

Do you habitually clench or grind your teeth during the day or night?  Yes  No

Have you ever been told you have gum problems?  Yes  No

Have you ever been seen by a gum specialist/Periodontist?  Yes  No

**For Women**

Are you using a prescribed method of birth control?  Yes  No

Are you pregnant? :  Yes  No    Week #: \_\_\_\_\_    Are you nursing? :  Yes  No

**Medical History**

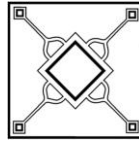
Your current physical health is:  Good     Fair     Poor

Do you have a personal physician?  Yes  No    Physician's Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_    Date of last visit: \_\_\_\_\_

Are you currently under the care of a physician?  Yes  No    If Yes, please explain:

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



Are you taking any **prescription medications** or **over-the-counter** or **herbal drugs**?  Yes  No

Please list each one:

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Have you ever taken Fosamax (Boniva), or any other bisphosphonate:  Yes  No

Have you ever had any of the following diseases or medical problems?

- |                                       |  |                                |  |
|---------------------------------------|--|--------------------------------|--|
| Abnormal Bleeding                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Alcohol / Drug abuse           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>Artificial Bones/Joints/Valves</b> | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer/Chemotherapy            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Colitis                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Congenital Heart Defect</b> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty Breathing           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting Spells                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Attack                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Heart Murmur</b>            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>Heart Surgery</b>                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes / Fever Blisters        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV+ / AIDS                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hospitalized for any reason           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liver Disease                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>Mitral Valve Prolapse</b>          | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Pacemaker</b>               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Psychiatric Problems                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic/Scarlet Fever               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sickle Cell Disease/Traits            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Problems                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tuberculosis                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Venereal Disease                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol               | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please list any serious medical condition(s) that you have ever had:

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I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date