Patient Information

Patient Name _____ _____ Date _____
Last First MI (Preferred Name)

Social Security # _____ Birth Date _____ Best time to call _____

Phone (Home) _____ (Work) _____ Ext _____ (Cell) _____

Address _____
Street Apt. # City State Zip Code

E-Mail Address _____ Gender M or F Married Single Child Other

Emergency Contact Name and Phone# _____

How did you find us: ☐ Insurance Website ☐ Drive By ☐ Yellow Pages ☐ Other _____

Primary reason for this dental appointment: ☐ Emergency ☐ Consultation ☐ Cleaning ☐ Other _____

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No

Do you have dental examinations on a routine basis? Last visit _____ Yes No

Do you want to change anything about your smile? _____ Yes No

Do you have bad breath? _____ Yes No

Do your gums bleed? _____ Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? Do you grind your teeth? _____ Yes No

Does food get caught between your teeth? Any loose teeth? _____ Yes No

Do you think you have active decay or gum disease? _____ Yes No

Do you have sensitivity to hot, cold or sweet? Discuss _____ Yes No

Do you want to keep your remaining teeth? _____ Yes No

Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No

Have your past experiences in a dental office always been positive? _____ Yes No

Name of previous dentist (optional): _____

Medical History

Are you under a physician's care now? Why? _____ Yes No

Name of Physician: _____ Phone _____

Have you ever been hospitalized or had a major operation? Discuss _____ Yes No

Have you ever had a serious injury to your head or neck? Discuss _____ Yes No

Are you taking any medications, pills, or drugs? Discuss _____ Yes No

Are you on a special diet? _____ Yes No

Are you allergic to any medications or substances? Please check box below. Yes No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex (gloves) ☐ Other _____

Women (Please check): ☐ Pregnant/ trying to get pregnant--How long _____ ☐ Nursing ☐ Taking oral Contraceptive ☐ None

Do you now have or have you ever had any of the following? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment…Premedication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No
Aids*	☐	☐	**Bruise Easily**	☐	☐	**Glaucoma**	☐	☐	**Pain in Jaw Joints**	☐	☐
Angina/ Chest Pain*	☐	☐	**Blood Disease**	☐	☐	**Hypoglycemia***	☐	☐	**Parathyroid Disease**	☐	☐
Artificial Heart Valve*	☐	☐	**Bloody Sputum**	☐	☐	**Hepatitis A**	☐	☐	**Renal Disease**	☐	☐
Bacterial Endocarditis*	☐	☐	**Breathing Problem**	☐	☐	**Hepatitis B or C**	☐	☐	**Recent Weight Loss**	☐	☐
Congenital Heart Disorder*	☐	☐	**Chemotherapy**	☐	☐	**HIV Positive**	☐	☐	**Recent Blood Transfusion**	☐	☐
Heart Attack/ Failure*	☐	☐	**Cancer**	☐	☐	**High Blood Pressure**	☐	☐	**Rheumatism**	☐	☐
Heart Murmur*	☐	☐	**Convulsions**	☐	☐	**Hay Fever**	☐	☐	**Radiation**	☐	☐
Heart Pace Maker*	☐	☐	**Cold Sore**	☐	☐	**Herpes**	☐	☐	**Shortness of Breath**	☐	☐
Heart Surgery*	☐	☐	**Cortisone Medicine**	☐	☐	**Hives/ Rash**	☐	☐	**Stomach/ Intestinal Disease**	☐	☐
Heart Trouble/ Disease*	☐	☐	**Diabetes**	☐	☐	**Hemophilia**	☐	☐	**Swelling Limbs**	☐	☐
Irregular Heart Beat*	☐	☐	**Drug Addiction/ Alcoholism**	☐	☐	**Jaundice**	☐	☐	**Sinus Trouble**	☐	☐
Mitral Valve Prolapse*	☐	☐	**Dizziness**	☐	☐	**Kidney Problem**	☐	☐	**Stroke**	☐	☐
Rheumatic Fever*	☐	☐	**Epilepsy or Seizures**	☐	☐	**Leukemia**	☐	☐	**Scarlet Fever**	☐	☐
Anemia	☐	☐	**Excessive Bleeding**	☐	☐	**Low Blood Pressure**	☐	☐	**Tuberculosis**	☐	☐
Asthma	☐	☐	**Excessive Thirst**	☐	☐	**Liver Disease**	☐	☐	**Tumors or Growths**	☐	☐
Allergies (Medicines)	☐	☐	**Emphysema**	☐	☐	**Lung Disease**	☐	☐	**Thyroid Disease**	☐	☐
Allergies (Pollen/ Dust)	☐	☐	**Frequent Diarrhea**	☐	☐	**Nervousness**	☐	☐	**Unexplained Fever**	☐	☐
Alzheimer's Disease	☐	☐	**Fainting**	☐	☐	**Night Sweats**	☐	☐	**Ulcers**	☐	☐
Artificial Joints*	☐	☐	**Frequent Cough**	☐	☐	**Psychiatric Care**	☐	☐	**Venereal Disease**	☐	☐
Arthritis/ Gout	☐	☐	**Fever Blister**	☐	☐						

Have you ever had any other serious illness not check above? Discuss_____ Yes No

Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date_____
Signature of patient, Parent or Guardian

Medical Updates

I have read my MEDICAL HISTORY dated and confirm that it adequately states past and present conditions.

Date	Please write below if there are any changes	Patient's Signature
_____	_____	_____ ☐
_____	_____	_____ ☐
_____	_____	_____ ☐
_____	_____	_____ ☐
_____	_____	_____ ☐
_____	_____	_____ ☐
_____	_____	_____ ☐
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_____	_____	_____ ☐
_____	_____	_____ ☐
_____	_____	_____ ☐
_____	_____	_____ ☐
_____	_____	_____ ☐

Please mark if you have a history of the following conditions.

Yes	No	
☐	☐	Prosthetic heart valve
☐	☐	Previous history of bacterial endocarditis
☐	☐	Congenital heart malformation
☐	☐	Rheumatic heart disease
☐	☐	Valvular disfunctions
☐	☐	Hypertrophic cardiomyopathy
☐	☐	Mitral valve prolapse with valvular regurgitation
☐	☐	Less than 6 months after surgical repair of septal defects/ patient ductus arteriosis
☐	☐	Heart valve damage

X _____ Date _____ Relationship to Patient _____

Signature of Patient or Guarantor of Payment