

Best Appointment Day/Time _____ Date _____

Name _____ Date of Birth ____ - ____ - ____

Home Address _____ City _____ State ____ Zip Code _____

Phone: Home _____ Business _____ Ext _____ Cell/ Pager _____

Social Security # ____ - ____ - ____ Marital Status S M D W E-mail: _____

Occupation _____ Employer _____ Dental Insurance Co. _____

Policy in the Name of _____ Social Security # of Policy Holder ____ - ____ - ____

Employer of Policy Holder _____ Policy Holder's Date of Birth ____ - ____ - ____

General Dentist _____ Referred By _____ Pharmacy/Phone # _____

Medical History

1. How is your general health at this time? _____

2. Do you have or have you ever had any of the following conditions?

<input type="checkbox"/> Joint Replacement Date _____	<input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> Tuberculosis (TB)
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Stroke Date _____	<input type="checkbox"/> Hepatitis A B C / Liver Disease
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Allergies	<input type="checkbox"/> Alcoholism/Drug Addiction
<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> HIV Positive
<input type="checkbox"/> Heart Valve replacement/shunts	<input type="checkbox"/> Emphysema	<input type="checkbox"/> A.I.D.S.
<input type="checkbox"/> Rheumatic Fever Date _____	<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Blood Disorders
<input type="checkbox"/> Pacemaker Date _____	<input type="checkbox"/> Arthritis/Rheumatism	<input type="checkbox"/> Anemia
<input type="checkbox"/> Heart Disease/attack	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Cancer/ Tumors / Radiation
<input type="checkbox"/> Heart Surgery Date _____	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Epilepsy / Seizures
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Diabetes Type _____

Women Only:

Are you pregnant? Y N Expected delivery date _____

Do you take birth control pills? Y N Have you reached menopause? Y N

3. Have you ever had any serious illness or operation? Y N If yes, what and when: _____

4. Do you have tendency to prolonged bleeding following injury or surgery? Y N

5. Do you take any blood thinners (anti-coagulants) or aspirin or Vitamin E? Y N

6. Are you allergic to or have you reacted adversely to any drug or medicine? Y N

Please list and explain: _____

7. Please list any Prescription medications you are presently taking:

_____ for _____	_____ for _____
_____ for _____	_____ for _____
_____ for _____	_____ for _____

8. Please list any over the counter medications, herbs and/or vitamins you are presently taking: _____

9. Do you have any medical condition not mentioned above? Y N If yes, please explain: _____

10. Name of your Physician _____ Approximate Date of your last physical _____

Hygienist Updates: _____

Dental History

1. Nature of your dental problem _____
2. Are you having pain or discomfort at this time? Where? _____ Y N
3. Are any of your teeth sensitive to hot, cold, sweet or sour? Where? _____ Y N
4. Do you have sores in or around your mouth? Where? _____ Y N
5. Do your gums bleed? If so, when? _____ Y N
6. Have you ever had periodontal treatment? Y N
If yes, When? _____
What? _____
Where? _____
7. Do you have any breathe odor or unpleasant taste? _____ Y N
8. Do you have loose teeth? If yes, where? _____ Y N
9. Do you have any popping, grinding, locking or pain in either jaw joint? _____ Y N
10. Has your dental care been regular? Y N
11. How long ago was your last dental cleaning? 3 mons. 4 mons. 6mons. Other _____
12. How often do you have your teeth cleaned? 3 mons. 4 mons. 6mons. Other _____
13. When was the last time you had dental x-rays taken? 6 mons. 1 yr. 5 yr. Other _____
14. How many times a day do you brush your teeth? once twice three Other _____
15. Do you floss? Y N How often? daily 2-3x week weekly Other _____
16. Do you have any removable dental appliances/partial/dentures? _____ Y N
17. Have you ever had orthodontic treatment (braces)? If yes, when? _____ Y N
18. Do you smoke? Y N If yes, how much? _____
19. Have you smoked in the past? Y N Quit date _____
20. Do you chew tobacco, use snuff or smoke cigars? Y N How often? _____
21. Have you ever had serious problems with dental treatment? Y N
If yes, please explain _____

22. Have you had any unpleasant dental experiences or is there anything about dentistry you strongly dislike? _____

I certify that the above information is complete and accurate.

Patient Signature (Parent/Guardian if minor)

Date

Dental History