PATIENT INFORMATION

First Name______________________________ MI ______ Last Name________________________________ Nickname_____________

Home Phone ___________________________ Work Phone ___________________________ Cell Phone ____________________________

Date of Birth ___________________________ ❑ Male ❑ Female SS#____

Address ____ City______________________ State _______ Zip ______________

Employer ____

State ID/Driver's License # _____________________________________ Email Address ____

Name of Physician____ Physician Phone_______________________

Emergency Contact: ________________________________ Relationship______________ Phone ________________________________

How did you hear about our office?____

PATIENT HEALTH HISTORY

Do YOU have a history of:

AIDS/HIV Positive ❑	Excessive Bleeding ❑	Jaundice ❑	Respiratory Problems ❑
Alcoholism ❑	Epilepsy ❑	Kidney Disease ❑	Rheumatic Fever ❑
Allergies ❑	Glaucoma ❑	Kidney dialysis ❑	Rheumatism ❑
Anemia ❑	Hay Fever ❑	Latex Sensitivity ❑	Scarlet Fever ❑
Arthritis ❑	Head Injuries ❑	Lupus ❑	Seizures/Fainting Spells ❑
Asthma ❑	Hearing Impaired ❑	Low Blood Pressure ❑	Sinus Problems ❑
Blood Disease ❑	Heart Disease ❑	Malignancies ❑	Sleep Apnea ❑
Stomach Ulcers ❑	Bone Disease ❑	Heart Valve, Murmur ❑	Mitral Valve Prolapse ❑
Stroke ❑	Cancer ❑	Hepatitis/Liver Disease ❑ *Type(s)*__________	Neck & Back Problems ❑
Thyroid Disease ❑	Chemical Dependency ❑		Nervous Problems ❑
Tuberculosis ❑	Chest Pain ❑	Hepatitis Carrier ❑	Pacemaker ❑
Tumors or Growths ❑	Circulatory Problems ❑	High Blood Pressure ❑	Prosthetic Joints ❑
Ulcers ❑	Convulsions/Seizures ❑	Hip/Joint Replacement ❑	Psychiatric Care ❑
Venereal Disease ❑ *(Sexually Transmitted Disease)*	Diabetes ❑	HPV ❑	Radiation Treatment ❑

MEDICAL QUESTIONS

Are you allergic to any medications? ❑ **Yes** ❑ **No**

If yes, please list:_____________________________________

____

List any medications you are taking, including nonprescription drugs: ____

____

Are you in good health? ❑ Yes ❑ No

Date of last medical exam?______________________________

Have you ever been hospitalized? ❑ Yes ❑ No

If yes, what was the reason?_____________________________

____

____

Do you have any disease/problem you think we should know about? ❑ Yes ❑ No

If yes, please explain: __________________________________

____

Have you had a transplant operation that has depressed your immune system? ❑ Yes ❑ No

Have you had an allergic reaction to bananas? ❑ Yes ❑ No

Do you smoke or chew tobacco? ❑ Yes ❑ No

Have you had heart surgery? ❑ Yes ❑ No

Are you now under the care of a physician? ❑ Yes ❑ No

Are you taking or have ever taken bisphosphonates? *(Fosamax or Actonel for osteoporosis, chemotherapy, etc)* ❑ Yes ❑ No

FOR WOMEN ONLY:

Are you taking birth control pills? . . . . ❏ Yes ❏ No

Are you nursing/breastfeeding? . . . . ❏ Yes ❏ No

Are you pregnant? . . . . ❏ Yes ❏ No

Is there a possibility of pregnancy? . . . . ❏ Yes ❏ No

Expected delivery Date: ________________

NOTE: *Antibiotics (such as penicillin) may alter the effect of birth control pills.*
Consult your physician/gynecologist for assistance regarding additional methods of birth control.

DENTAL HISTORY INFORMATION

Reason for today's visit? ________________________________

____

____

Date of last dental visit? ________________________________

Name of your previous dentist ___________________________

____

Have you ever had an oral cancer screening? . . . . ❏ Yes ❏ No

Do your gums bleed when you brush? . . . . ❏ Yes ❏ No

Have you or a family member even been treated for periodontal disease? . . . . ❏ Yes ❏ No

Have you ever had complications from an extraction?. . . . . ❏ Yes ❏ No

Have you ever had a popping or clicking near your ear when you chew? . . . . ❏ Yes ❏ No

Are you prone to frequent headaches?. . . . . ❏ Yes ❏ No

Do you grind or clench your teeth? . . . . ❏ Yes ❏ No

Do you have sores, blisters, or swelling on your gums, lips, or cheeks?. . . . . ❏ Yes ❏ No

Have you ever had orthodontic treatment? . . . . . ❏ Yes ❏ No

Do you snore?. . . . . ❏ Yes ❏ No

Do you have problems with bad breath? . . . . ❏ Yes ❏ No

Have you ever used an electric toothbrush? . . . . . ❏ Yes ❏ No

Are your teeth sensitive to hot, cold, or pressure? . . . . ❏ Yes ❏ No

On a scale from 1 to 5, with 5 being the highest, how happy are you with your smile/oral health?

1 2 3 4 5

If you could change something about your smile, what would it be?

- ❏ Whiter
- ❏ Straighter
- ❏ Close space(s)
- ❏ Replace silver/black mercury filling with tooth colored restorations
- ❏ Repair chipped teeth
- ❏ Replace missing teeth
- ❏ Less gums showing
- ❏ Replace old crowns or caps that don't match
- ❏ Other ______________________________

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I certify that I have read and understand the questions, above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Adult/Guardian: *I hereby consent to the treatment indicated on my examination form, including the use of any anaesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.*

*Patient*____ *Date*__________________

*Parent/Guardian*_______________________________________ *Date*__________________

*Doctor's Signature*_____________________________________ *Date*__________________