PATIENT INFORMATION

Patient Name: _____ Date: _____
Last *First* *MI*

☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Divorced ☐ Widowed ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Best time to call: _____

Address: _____
Street Apt# City State Zip Code

Whom may we thank for referring you to our practice? _____

MEDICAL INFORMATION

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV+
☐ Alcohol Usage:
☐ Social
☐ Moderate
☐ Heavy
☐ None
☐ Allergies _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis ____
☐ High Blood Pressure
BP:____/____ P:_____
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due Date: _____
☐ Radiation Treatment/ Chemo
☐ Respiratory Problems
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease

Do you smoke?
☐ Yes ☐ No
Packs per day ____

Check if you take:
☐ Aspirin Daily
☐ Motrin Daily

Have you taken:
☐ Fen-Phen
☐ Redux

Prosthetic Implants:
☐ Yes ☐ No

Drug Allergies:
_____
_____
_____
_____
_____

Current Medications:
_____
_____
_____
_____
_____

Have you been admitted to a hospital or needed emergency care during the past two years?
If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

Name of Physician: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
Signature of patient, parent, or guardian *Date*

DENTAL INFORMATION

Reason for today's visit: _____

Former Dentist: _____

Date of last dental visit: _____ Date of last dental x-rays: _____

Please check to indicate if you have had any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Blister on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette, pipe, or cigar smoking
- ☐ Clicking or popping jaw
- ☐ Discolored teeth
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between teeth
- ☐ Foreign objects
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain or tiredness
- ☐ Lip or cheek biting
- ☐ Loose teeth or broken fillings
- ☐ Mouth breathing
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold, heat, or sweet
- ☐ Sensitivity when biting
- ☐ Sores or growths in mouth

How often do you floss? _____
How often do you brush? _____

Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No
If no, what would you like to see improved? _____

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No _____ Initial _____ Date
If yes, please explain change: _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No _____ Initial _____ Date
If yes, please explain change: _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No _____ Initial _____ Date
If yes, please explain change: _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No _____ Initial _____ Date
If yes, please explain change: _____