## PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes

in your health, please tell us. If you have any questions, don't	hesitate to ask.	
Patient name:	Date of birth: Sex:	Age:
Home address:	City: State:	Zip:
Billing address (if different):	City: State:	Zip:
Home phone: Cell: E-mail:	Driver's license #:	State:
Home Phone: Cell:	E-mail:	
Spouse's name & phone #:	Emergency phone # (other than spouse):	
Primary dental insurance:	Group #:	
Secondary dental insurance:	Group #:	
Subscriber's name:	Date of birth: SS #:	
Name of your medical doctor:	Date of last visit to medical doctor:	
Name of previous dentist:	Date of last visit to dentist:	
Referred to us by:		
Yes No Are you apprehensive about dental treatment?	How often do you brush?	Yes No
Have you had problems with previous dental treatment?  Do you gag easily?	Does your jaw make noise so that it bothers yo	
Do you wear dentures?	or others?	
	Do you clench or grind your jaws frequently?	
Does food catch between your teeth?	Do your jaws ever feel tired?	
Do you have difficulty in chewing your food?	Does your jaw get stuck so that you can't open	freely?
Do you chew on only one side of your mouth?	Does it hurt when you chew or open wide to t	ake a bite?
Do you avoid brushing any part of your mouth because of pain?	Do you have earaches or pain in front of the ea	ars?
Do your gums bleed easily?	Do you have any jaw symptoms or headaches	
Do your gums bleed when you floss?	upon awaking in the morning?	
Do your gums feel swollen or tender?	Does jaw pain or discomfort affect your appet	-
Have you ever noticed slow-healing sores in or	sleep, daily routine, or other activities?	
about your mouth?	Do you find jaw pain or discomfort extremely	
Are your teeth sensitive?	frustrating or depressing?	
Do you feel twinges of pain when your teeth come in	Do you take medications or pills for pain or di (pain relievers, muscle relaxants, antidepressar	
contact with:	Do you have a temporomandibular (jaw) disor	
Hot foods or liquids?	(TMD)?	
Cold foods or liquids?	Do you have pain in the face, cheeks, jaws, joi	
Sours?	throat, or temples?	
Do you take fluoride supplements?	Are you unable to open your mouth as far as y	ou want?
	Are you aware of an uncomfortable bite?	
Are you dissatisfied with the appearance of your teeth?	Have you had a blow to the jaw (trauma)?	

Are you a habitual gum chewer or pipe smoker?

Do you prefer to save your teeth?

Do you want complete dental care?

MEDICAL HEALTH HISTORY: Do you have, or have you had, any of the following?

	Yes	No	v	es No	
Heart Problems			Diabetes	es No	
Chest pain			Urinate more than 6 times a day	1 7	
Shortness of breath		F	Thirsty or mouth is dry much of the time		
Blood pressure problem			Family history of diabetes		
Heart murmur					
Heart valve problem			Tuberculosis or other respiratory disease		
Taking heart medication			Do you drink alcohol?		
Rheumatic fever			If so, how much?		
Pacemaker					
Artificial heart valve			Do you smoke?		
Diag d Problems	$\neg$		If so, how much?		
Blood Problems		-	Hepatitis, jaundice, or liver trouble		
Easy bruising Frequent nosebleeds		<u> </u>	Herpes or other STD		
Abnormal bleeding		_			
Blood disease (anemia)			HIV-positive/AIDS		
Ever require a blood transfusion?			Glaucoma		
•		_	Do you wear contact lenses?		
Allergy Problems		<u> </u>			
Hay fever		_	History of head injury?		
Sinus problems		_	Epilepsy or other neurological disease?		
Skin rashes		_			
Taking allergy medication		_	History of alcohol or drug abuse?		
Asthma	_ '	1	Do you have any disease, condition, or probler	n not listed	
Intestinal Problems			previously that you feel we should know ab	out?	
Ulcers			If so, please describe:		
Weight gain or loss					
Special diet					
Constipation/Diarrhea		ļ_	During the past 12 months, have you taken		
Kidney or bladder problems			any of the following?	Yes	No
Bone or Joint Problems			Antibiotics or sulfa drugs		
Arthritis			Anticoagulants (e.g., Coumadin)	Ħ	H
Back or neck pain		_	High blood pressure medicine	H	H
				Н	
Joint replacement			Tranquilizers	H	H
Joint replacement			Tranquilizers Insulin, Orinase, or similar drug		
Joint replacement			Tranquilizers Insulin, Orinase, or similar drug Aspirin		
Joint replacement	_		Tranquilizers Insulin, Orinase, or similar drug Aspirin Digitalis or drugs for heart trouble		
Joint replacement (e.g., total hip, pins, or implants) Fainting Spells, Seizures, or Epilepsy Stroke(s)	_ ¬		Tranquilizers Insulin, Orinase, or similar drug Aspirin Digitalis or drugs for heart trouble Nitroglycerin		
Joint replacement	_		Tranquilizers Insulin, Orinase, or similar drug Aspirin Digitalis or drugs for heart trouble Nitroglycerin Cortisone (steroids)		
Joint replacement (e.g., total hip, pins, or implants) Fainting Spells, Seizures, or Epilepsy Stroke(s)	_		Tranquilizers Insulin, Orinase, or similar drug Aspirin Digitalis or drugs for heart trouble Nitroglycerin Cortisone (steroids) Natural remedies		
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Joint replacement (e.g., total hip, pins, or implants)  Fainting Spells, Seizures, or Epilepsy Stroke(s)  Frequent or severe headaches Prequent cough or swollen glands Premedications required by physician Cancer/Tumor Premedications required by physician Cancer/Tumor Premedications required by physician Pr	_	es No	Tranquilizers Insulin, Orinase, or similar drug Aspirin Digitalis or drugs for heart trouble Nitroglycerin Cortisone (steroids) Natural remedies Nonprescription drug/supplements Other  Women  Are you taking contraceptives or other hormones? Are you pregnant? If so, expected delivery date: Are you nursing?		No
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