

welcome

PATIENT NUMBER

Patient's Name

Last

First

Initial

Date of Birth

COMMENTS

1. Purpose of initial visit _____
 2. Are you aware of a problem? _____
 3. How long since your last dental visit? _____
 4. What was done at that time? _____
 5. Previous dentist's name _____
Address: _____ Tel. _____
 6. When was the last time your teeth were cleaned? _____
- CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.
7. Have you made regular visits?YES NO
How often: _____
 8. Were dental x-rays taken?YES NO
 9. Have you lost any teeth or have any teeth been removed?YES NO
Why? _____
 10. Have they been replaced?YES NO
 11. How have they been replaced?
a. Fixed bridge _____ Age _____
b. Removable bridge _____ Age _____
c. Denture _____ Age _____
d. Implant _____ Age _____
 12. Are you unhappy with the replacement?YES NO
If yes, explain _____
 13. Would you like to know about permanent replacements?YES NO
 14. Have you ever had any problems or complications with previous dental treatment?YES NO
If yes, explain: _____
 15. Do you clench or grind your teeth?YES NO
 16. Does your jaw click or pop?YES NO
 17. Have you experienced any pain or soreness in the muscles or your face or around your ear?YES NO
 18. Do you have frequent headaches, neckaches or shoulder aches?YES NO
 19. Does food get caught in your teeth?YES NO
 20. Are any of your teeth sensitive to: ☐ Hot? ☐ Cold? ☐ Sweets? ☐ Pressure?YES NO
 21. Do your gums bleed or hurt?YES NO
When? _____
 22. Do you experience dry mouth?YES NO
 23. How often do you brush your teeth? _____ When? _____
 24. Do you use dental floss?YES NO
How often? _____
 25. Are any of your teeth loose, tipped, shifted or chipped?YES NO
 26. Are you unhappy with the appearance of your teeth?YES NO
 27. How do you feel about your teeth in general? _____
 28. Do you feel your breath is offensive at times?YES NO
 29. Have you ever had gum treatment or surgery?YES NO
What? _____
Where? _____
When? _____
 30. Have you had any orthodontic work? _____
 31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
 32. Do you have any questions or concerns?YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____

DATE _____

DENTIST'S SIGNATURE _____

DATE _____

ANEST.

MED. ALERT

DENTAL HISTORY

PATIENT REGISTRATION

ID: _____

Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder

Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient) _____

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder**Patient Information**

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.**Section 2**Employment Status: ☐ Full Time ☐ Part Time ☐ RetiredStudent Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Additional Comments: _____

Primary Insurance InformationName of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance InformationName of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____
- Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No _____
- Are you on a special diet? ☐ Yes ☐ No
- Do you use tobacco? ☐ Yes ☐ No
- Do you use controlled substances? ☐ Yes ☐ No
- Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing?
☐ Taking oral contraceptives?

Are you allergic to any of the following?

- ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs
- ☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| | | | | <input type="checkbox"/> Venereal Disease |
| | | | | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____