



Patient's Name: _____

First Middle Last

Date of Birth: _____ Age: _____ Sex: M F

Social Security Number: _____

Home Address: _____

City _____ State _____ Zip _____

What's the best way for us to contact you? _____

Telephone: Home _____ Cell _____ Work _____

Name of Employer: _____

Occupation: _____

E-mail Address: _____

Spouse: Name _____ Employer _____

If Patient is a minor: Parents' Names _____

Name of Dentist Who Referred You: _____

Preferred Pharmacy: _____

Dental Insurance Co: _____

Is there anyone you give us permission to share your information with? Yes No

If so, who? _____

Your privacy is of our utmost concern. All employees of our office will do everything possible to protect it. A copy of our complete privacy policy is located in our waiting room.

Patient Dental History

Yes No
Do your gums bleed while brushing or flossing?

Are your teeth sensitive?

Are you experiencing pain from your mouth at this time?
If so, explain: _____

How many times have you had your teeth cleaned in the last 5 years? _____

Have you had previous periodontal treatments?
When? _____

Would you be disturbed if you had to lose your teeth and wear false teeth?

Have you ever fainted in a dental office?

Have you experienced any of the following problems in your jaw?

Clicking?

Pain (joint, ear, side of face)?

Difficulty in opening or closing?

Difficulty in chewing?

Do you have frequent headaches?

Do you clench/grind your teeth?
If so, do you wear a night guard?

Do you bite your lips or cheeks frequently?

Have you had any orthodontics (braces)?

Have you ever had any prolonged bleeding following extractions?

Patient Medical History

Physician: _____

Date of Last Exam: _____

Height: _____ Weight: _____

Are you under medical treatment now? Yes No

Have you ever been hospitalized for any surgical operation or serious illness? Yes No

Are you taking any medication(s) including over-the-counter medications/supplements? Yes No
If yes, what are you taking?

Are you taking a prescription blood thinner? Yes No
(e.g., Plavix, Coumadin)

Do you use tobacco? Yes No

Have you been told to take an antibiotic pre-medication prior to dental work? Yes No

Are you allergic to or have you had reactions to the following? Yes No

Local Anesthetics (e.g. Novocain) Yes No

Penicillin or other Antibiotics Yes No

Sulfa Drugs Yes No

Sedatives Yes No

Other _____

Can you take NSAIDS? (e.g., Ibuprofen, Naproxen) Yes No

Women Only:

Are you pregnant or think you may be? Yes No

Are you nursing? Yes No

Are you taking birth control? Yes No

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

	Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>

Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
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Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
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Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>
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Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
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Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	HPV	<input type="checkbox"/>	<input type="checkbox"/>
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Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Issues/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
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Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
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Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
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Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
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AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>
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Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
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Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
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Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
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Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
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Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
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Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
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Angina	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
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Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
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Anemia	<input type="checkbox"/>	<input type="checkbox"/>			
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Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent of minor

Date