



PATIENT INFORMATION

Welcome to our office. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If you have any questions, don't hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____

Address: _____ Apt/Unit: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ E-mail: _____

Employer: _____ Occupation: _____ Work phone: _____

Emergency contact name: _____

Emergency phone & relationship: _____

Primary dental insurance: _____

ID #: _____ Group #: _____

Secondary dental insurance: _____

ID #: _____ Group #: _____

Subscriber name & relationship: _____

Date of birth: _____

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: _____

DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had problems with previous dental treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you gag easily? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed easily? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you floss? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever noticed slow-healing sores in or about your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids? _____	<input type="checkbox"/>	<input type="checkbox"/>
Cold foods or liquids? _____	<input type="checkbox"/>	<input type="checkbox"/>
Sour? _____	<input type="checkbox"/>	<input type="checkbox"/>
Sweet? _____	<input type="checkbox"/>	<input type="checkbox"/>
How often do you brush? _____		
How often do you floss? _____		
Does your jaw make noise so that it bothers you or others? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your jaws frequently? _____	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Do your jaws ever feel tired? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does your jaw get stuck so that you can't open freely? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does it hurt when you chew or open wide to take a bite? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have earaches or pain in front of the ears? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any jaw symptoms or headaches upon awaking in the morning? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does jaw pain or discomfort affect your appetite, sleep, daily routine or other activities? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you find jaw pain or discomfort extremely frustrating or depressing? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you take medications or pills for pain or discomfort? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a temporomandibular (jaw) disorder (TMD/TMJ)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you unable to open your mouth as far as you want? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of an uncomfortable bite? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a blow to the jaw (trauma)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you a habitual gum chewer or pipe smoker? _____	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HEALTH HISTORY:

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

	Yes	No
Heart Problems		
Chest pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath _____	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking heart medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker _____	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve _____	<input type="checkbox"/>	<input type="checkbox"/>

Blood Problems		
Easy bruising _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds _____	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease (e.g. anemia) _____	<input type="checkbox"/>	<input type="checkbox"/>
History of blood transfusion _____	<input type="checkbox"/>	<input type="checkbox"/>

Allergy Problems		
Hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>

Intestinal Problems		
Ulcers _____	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or loss _____	<input type="checkbox"/>	<input type="checkbox"/>
Special diet _____	<input type="checkbox"/>	<input type="checkbox"/>
Chronic constipation _____	<input type="checkbox"/>	<input type="checkbox"/>
Chronic diarrhea _____	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder problems _____	<input type="checkbox"/>	<input type="checkbox"/>

Bone or Joint Problems		
Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis _____	<input type="checkbox"/>	<input type="checkbox"/>
Back or neck pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement _____ (e.g. total hip, pins, or implants)	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells, Seizures or Epilepsy _____	<input type="checkbox"/>	<input type="checkbox"/>
Stroke(s) _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough or swollen glands _____	<input type="checkbox"/>	<input type="checkbox"/>
Pre-medication required by physician _____	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumor _____	<input type="checkbox"/>	<input type="checkbox"/>

Are you allergic, or have you reacted adversely, to any of the following?	Yes	No
Local anesthetics ("Novocaine") _____	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin/Amoxicillin _____	<input type="checkbox"/>	<input type="checkbox"/>
Other Antibiotic _____	<input type="checkbox"/>	<input type="checkbox"/>
Latex or rubber dam _____	<input type="checkbox"/>	<input type="checkbox"/>
Acetaminophen _____	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, Ibuprofen or other NSAID _____	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to metals _____	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics _____	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

	Yes	No
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Urinate more than 6 times a day _____	<input type="checkbox"/>	<input type="checkbox"/>
Thirsty or mouth is dry much of the time _____	<input type="checkbox"/>	<input type="checkbox"/>
Family history of diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or other respiratory disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Do you smoke? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Hepatitis, jaundice, or liver trouble _____	<input type="checkbox"/>	<input type="checkbox"/>
Herpes or other STD _____	<input type="checkbox"/>	<input type="checkbox"/>
HIV-positive/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses? _____	<input type="checkbox"/>	<input type="checkbox"/>
History of head injury? _____	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or other neurological disease? _____	<input type="checkbox"/>	<input type="checkbox"/>
History of alcohol or drug abuse? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any disease, condition, or problem not listed previously that you feel we should know about?		
If so, please describe: _____		

During the past 12 months, have you taken any of the following?	Yes	No
Antibiotics or sulfa drugs _____	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants (e.g. Coumadin, Warfarin) _____	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure medicine _____	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone (steroids) _____	<input type="checkbox"/>	<input type="checkbox"/>
Insulin, Orinase, or similar drug _____	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerin _____	<input type="checkbox"/>	<input type="checkbox"/>
Digitalis or drugs for heart trouble _____	<input type="checkbox"/>	<input type="checkbox"/>
Please list all current medications and supplements:		

Women	Yes	No
Are you taking contraceptives or other hormones? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, expected delivery date: _____		
Are you nursing? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you reached menopause? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, do you have any symptoms? _____		

Patient/Parent Signature: _____ Date: _____