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:_____

Social Security #:_____ E-mail:_____

Marital Status: □ Married □ Single □ Divorced □ Widowed

Home Address:_____City: _____State:_____ Zip:_____

Billing Address (if different):_____City_____State:_____ Zip:_____

Home Phone:_____Cell:_____Bus Phone:_____

Employer:_____Occupation:_____

Emergency Contact/ Relation:_____Phone #:_____

Primary Dental Insurance: _____Group #:_____

Subscriber's Name: _____Date of Birth: _____Social Security #::_____

Secondary Dental Insurance:_____Group #:_____

Subscriber's Name: _____Date of Birth: _____Social Security #::_____

Name of 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		Yes	No
Are you apprehensive about treatment?_____	□	□	Are you dissatisfied with the appearance of your teeth?____	□	□
Have you ever had any problems with previous dental treatment?_____	□	□	Are you interested in aesthetic dentistry?_____	□	□
Do you gag easily_____	□	□	Do you clench or grind your teeth frequently?_____	□	□
Do you wear dentures?_____	□	□	Do you ever have earaches or pain near the front of the ears?_____	□	□
Does food catch between you teeth?_____	□	□	Do you have any soreness in the jaws or any headaches upon awaking in the morning?_____	□	□
Do you have difficulty chewing your food?_____	□	□	Do you have past history of orthodontic treatment?_____	□	□
Do your gums bleed easily?_____	□	□	Have you ever had any problems with sleep apnea?_____	□	□
Do your gums bleed when you floss?_____	□	□	Are you taking any medication for osteoporosis?_____	□	□
Do your gums feel swollen or tender?_____	□	□	Have you ever taken the medication called Fen-Fen or Redux?_____	□	□
Have you ever noticed slow-healing sores in or around your mouth? _____	□	□	Have you ever had to be premedicated prior to receiving any dental treatment?_____	□	□
Have you ever noticed any pain when your teeth come in contact with:			Are you currently taking any blood thinners?_____	□	□
Hot foods or liquids?_____	□	□	How often do you brush? _____		
Cold foods or liquids?_____	□	□	How often do you floss? _____		
Sour/ Sweets?_____	□	□			

MEDICAL HEALTH HISTORY:

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

	Yes	No
Heart ailment or angina	□	□
Heart Murmur, mitral valve prolapse, heart defect	□	□
Rheumatic fever or rheumatic heart disease	□	□
Artificial heart valve	□	□
High or low blood pressure	□	□
Pacemaker	□	□
Tuberculosis or other lung problems	□	□
Kidney disease	□	□
Hepatitis or other liver disease	□	□
Blood transfusion	□	□
Diabetes	□	□
Neurological/ Psychiatric condition	□	□
Epilepsy, seizures, or fainting spells	□	□
Implant or Joint Replacement	□	□
Arthritis	□	□
Herpes or cold sores	□	□
AIDS or HIV positive	□	□
Anemia or blood disorders	□	□
Abnormal bleeding after surgery or trauma	□	□
Hay fever or sinus trouble	□	□
Allergies or hives	□	□
Asthma	□	□

	Yes	No
Cancer	□	□
Women:		
May be pregnant	□	□
Expected delivery date:		
Taking hormones or contraceptives	□	□

Are you allergic to, or have you reacted adversely to any of the following?

	Yes	No
Latex materials	□	□
Penicillin or other antibiotics	□	□
Local anesthetics ("Novocaine")	□	□
Codeine or other narcotics	□	□
Barbiturates, sedatives, or sleeping pills	□	□
Reaction/Sensitivity to metals	□	□

List any medications that you are currently taking: _____

_____

Do you have any disease, condition, or problem not listed above? _____

_____

Please add anything else you would like us to know about: _____

_____

Signature of patient (or parent) _____ Date _____