Patient's Name _____ **Date of Birth** _____ **Date** _____

Medical History

Have you been under the care of a physician during the past 2 years? ..... **Yes** **No**

Condition/s for which you are seeing a physician: _____

_____

Name and contact information of physician/s: _____

_____

_____

Do you have any allergies? ..... **Yes** **No**

Are you allergic to:

Penicillin	**Yes**	**No**	Codeine	**Yes**	**No**
Local anesthetic	**Yes**	**No**	Latex	**Yes**	**No**

Other: _____

Have you been treated in a hospital during the past 2 years? ..... **Yes** **No**

Have you **ever** had surgery? ..... **Yes** **No**

Please list surgery and date: _____

_____

Are you taking or have you taken any medications during the past year? ..... **Yes** **No**

Are you taking any of the following types of medications?

Aspirin	**Yes**	**No**	Bone density (Bisphosphonates)	**Yes**	**No**
Blood thinners	**Yes**	**No**	Steroids	**Yes**	**No**
Birth control	**Yes**	**No**	Hormone replacement therapy	**Yes**	**No**

Please list all medications and condition for which you are taking medication: _____

_____

_____

Have you had or do you have now:

	Yes	No
Heart		
Heart Disease	( )	( )
High cholesterol	( )	( )
Angina	( )	( )
Heart Attack	( )	( )
Previous bacterial endocarditis	( )	( )
Abnormal blood pressure	( )	( )
Congenital heart lesion	( )	( )
Artificial heart valves	( )	( )
Pacemaker	( )	( )
Rheumatic fever	( )	( )
Heart murmur	( )	( )
Fainting	( )	( )
Lung		
Difficulty breathing/Prolonged cough	( )	( )
Tuberculosis	( )	( )
Asthma	( )	( )
Liver		
Liver disease	( )	( )
Jaundice	( )	( )
Hepatitis	( )	( )
Alcoholism/Drug Dependency	( )	( )
Kidney		
Kidney disease	( )	( )
Dialysis	( )	( )
Bleeding Disorders		
Anemia	( )	( )
Prolonged bleeding	( )	( )
Sickle cell anemia	( )	( )
Stroke	( )	( )

	Yes	No
Nervous System		
Psychiatric condition	( )	( )
Anorexia/bulimia	( )	( )
Epilepsy	( )	( )
Drug dependency	( )	( )
Alzheimer's	( )	( )
Metabolic Conditions		
Diabetes	( )	( )
Thyroid	( )	( )
Other		
Lupus	( )	( )
Arthritis	( )	( )
Artificial joints	( )	( )
Tobacco use	( )	( )
Cancer	( )	( )
Radiation	( )	( )
Chemotherapy	( )	( )
Organ transplant	( )	( )
Sleep apnea	( )	( )
Polio	( )	( )
AIDS/HIV	( )	( )
Venereal disease	( )	( )
Herpes	( )	( )
Glaucoma	( )	( )
Ulcers	( )	( )
Inflammatory bowel disease	( )	( )
Acid reflux	( )	( )
Are you currently pregnant	( )	( )
Are you currently nursing	( )	( )

Any diseases, conditions or problems not previously listed? _____

_____

PATIENT INFORMATION

Date _____
Patient's Name _____
Last First Middle
Address _____
Street City State Zip
Home Phone _____ Birthdate _____ Social Security # _____
If patient is a minor, give parent's or guardian's name _____
Email Address _____
How did you hear of our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle Marital Status
Residence _____
Street City State Zip
Mailing Address _____
Street City State Zip
How long at this address? _____ Home Phone _____ Work Phone _____
Previous Address (if less than 3 years) _____
Street City State Zip
Social Security # _____ Birthdate _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Spouse's Name _____ Relationship to Patient _____
Last First Middle
Employer _____ Occupation _____ No. Years Employed _____
Social Security # _____ Birthday _____ Work Phone _____

INSURANCE INFORMATION

Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. Address _____
Insured's Employer _____
Do you have dual coverage? ( ) Yes ( ) No If Yes: _____
Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. Address _____
Insured's Employer _____

EMERGENCY INFORMATION

Name of Emergency Contact _____
Relationship to Patient _____
Phone _____

CONSENT

I, the undersigned (patient or legally responsible person) verify that the medical and dental information is correct. I authorize dental treatment to be rendered by the Dentist and his staff and assume financial responsibility.

Signature (Parent's signature if minor) _____

CONFIDENTIAL (for record and pretreatment evaluation)

Dental Health

When was your last dental visit? _____

Are you having any dental problems that require immediate attention? Yes No

Please describe: _____

_____

Do any of the following cause tooth discomfort? Hot Cold Sweet Chewing

Do you have any of the following problems:

Gums bleed while cleansing	Yes	No	Gums feel tender or swollen	Yes	No
Clench or grind teeth	Yes	No	Chew on both sides of mouth	Yes	No
Jaws feel tired or ache	Yes	No	Jaws click or pop	Yes	No
Frequent headaches	Yes	No	Earaches	Yes	No
Frequent cavities	Yes	No	Any loose teeth	Yes	No
Cracked or broken teeth	Yes	No	Any wear on teeth	Yes	No
Food traps	Yes	No	Missing teeth	Yes	No

Have you had periodontal treatment? Yes No

When _____

Have you had orthodontic treatment? Yes No

When _____

Do you have any missing teeth? Yes No

Have any missing teeth been replaced? Yes No

If so, how: ( ) Fixed bridge ( ) Partial Denture

( ) Dental Implant ( ) Complete Denture

Are you comfortable with the replacement? Yes No

Please describe: _____

Do you like your smile? Yes No

Have you had any cosmetic dentistry? Yes No

If yes, are you pleased with the results? Yes No

Please describe: _____

Have you ever had an unpleasant dental experience? Yes No

Please add anything you feel is important: _____

_____