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, please don't hesitate to ask.

Patient name_____ Today's date _____

Preferred Name _____

Date of birth _____ Age ____ Gender _____ SSN _____

Home address _____

City _____ State _____ Zip Code _____

Phone _____ Cell Phone _____ Email address _____

Billing address (if different from above) _____

Employer/occupation _____ Business phone _____

Spouse's name _____ Spouse's phone _____

Emergency contact and phone (other than spouse) _____

Primary dental insurance _____ Group number _____

Secondary dental insurance _____ Group number _____

Subscriber's name _____ Subscriber's insurance number _____

Date of birth _____ Age _____ Sex _____

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

Do you have or have you had any of the following?
(check all that apply)

☐ Apprehension about dental treatment
☐ Problems with previous dental treatment
☐ Want to save your teeth?
☐ Want complete dental care?

☐ Gag easily
☐ Wear dentures
☐ Food catches between your teeth
☐ Difficulty chewing your food
☐ Chew on only one side of your mouth
☐ Avoid brushing any part of your mouth because of pain
☐ Gums bleed easily
☐ Gums bleed when flossing
☐ Gums feel swollen or tender
☐ Notice slow-healing sores in or around your mouth
☐ Feel twinges of pain when your teeth come into contact with:
- ☐ Hot foods or liquids
- ☐ Cold foods or liquids
- ☐ Sour foods
- ☐ Sweet foods
- ☐ Take fluoride supplements

☐ Earaches or pain in front of your ears
☐ Had a blow to the jaw (trauma)
☐ Habitually chew gum?
☐ Smoke a pipe?
☐ Use chewing tobacco
☐ Jaw symptoms or headaches upon awaking in the morning
☐ Jaw pain or discomfort affecting your appetite, sleep, daily routine, or other activities
☐ Jaw pain or discomfort that is extremely frustrating or depressing
☐ Take medications for pain or discomfort (pain relievers, muscle relaxants, antidepressants)

How often do you brush? _____
How often do you floss? _____
☐ Your jaw makes noise so that it bothers you
☐ Or others
☐ Clench or grind your teeth frequently
☐ Jaws feel tired
☐ Jaw gets stuck so that you can't open freely
☐ Pain when you chew or open wide to take a bite
☐ Feel dissatisfied with the appearance of your teeth
☐ Aware of an uncomfortable bite
☐ Unable to open your mouth as far as you want
☐ Pain in the face, cheeks, jaws, joints, throat, or temples
☐ Temporomandibular (jaw) disorder (TMD)

Medical Health History

Do you have or have you had any of the following?
(check all that apply)

☐Heart problems
☐Hepatitis, jaundice or liver trouble
☐Hay fever
☐Chest pain
☐Shortness of breath
☐Blood pressure problem
☐Heart murmur
☐Heart valve problem
☐Back or neck pain
☐Rheumatic fever
☐Pacemaker
☐Artificial heart valve
☐Blood problems
☐Easy bruising

☐Do you drink alcohol?
If so, how much? _____
☐Epilepsy or other neurologic disease
☐Herpes or other STD
☐HIV positive/AIDS
☐Glaucoma
☐Do you wear contact lenses?
☐Head injury
☐Taking heart medication
☐History of alcohol or drug abuse

During the past 12 months, have you taken any of the following?

☐Antibiotics or sulfa drugs
☐Anticoagulants (e.g. Coumadin)
☐High blood pressure medicine

☐Frequent nosebleed/abnormal bleeding
☐Blood disease
☐Anemia
☐Ever require a blood transfusion?
☐Allergy problems
☐Arthritis
☐Sinus problems
☐Taking allergy medication
☐Asthma
☐Intestinal problems
☐Ulcers adversely
☐Weight gain or loss
☐Special diet
☐Constipation/diarrhea
☐Kidney or bladder problems
☐Fainting spells, seizures or epilepsy
☐Stroke(s)
☐Frequent or severe headaches
☐Thyroid problems
☐Persistent cough or swollen glands
☐Pre-medications required by physician
☐Cancer/tumor taking?
☐Diabetes
☐Urinate more than six times a day
☐Thirsty or mouth is dry much of the time
☐Family history of diabetes
☐Joint replacement (e.g. hip, pins, implants)
☐Tuberculosis or other respiratory disease
☐Bone or joint problems

☐Tranquilizers
☐Insulin, Tolbutamide or similar drug
☐Aspirin
☐Digitalis or drugs for heart trouble
☐Nitroglycerin
☐Cortisone (steroids)
☐Natural remedies
☐Nonprescription drug/supplements
☐Other: _____

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

☐Local anesthetics (Novocain)
☐Penicillin or other antibiotics
☐Sulfa drugs
☐Barbiturates, sedatives or sleeping pills
☐Aspirin, acetaminophen or ibuprofen
☐Codeine, Demerol or other narcotics
☐Metals
☐Latex or rubber dam
☐Other: _____
☐What medications are you currently taking?

_____
_____
_____

Women

☐Are you taking contraceptives or other hormones?
☐Are you pregnant?
☐If so, expected delivery date _____
☐Have you reached menopause?
☐If so, do you have symptoms?

_____ _____
Patient signature/legally authorized representative Date Date

_____ _____
Printed name if signed on behalf of the patient Relationship Relationship

_____ _____
Doctor Signature Date