

# PATIENT INFORMATION

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_ Nick Name: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 DOB: \_\_\_\_\_  Male  Female SS#: \_\_\_\_\_ Email: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 State ID/Driver's License #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
 Name of Physician: \_\_\_\_\_ Physician Phone: \_\_\_\_\_  
 In case of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

## Patient Health History

**Do you have a history of:**

	Yes	No		Yes	No		Yes	No		Yes	No
A.I.D.S./HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems/Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Latex Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Head injuries	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Malignancies	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Bone Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve, Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Neck & Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Type(s) _____			Nervous Problems/Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Carrier	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or growths	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Joints	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hip or Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	HPV	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>			

## Medical Questions

List any medications you are taking including nonprescription drugs: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have any disease/problem you think we should know about?  YES  No  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you allergic to any medications?  YES  No If yes, please list below:  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you in good health?  YES  No

Date of last medical exam: \_\_\_\_\_

Have you ever been hospitalized?  YES  No If yes, what was the problem  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you had a transplant operation that has depressed your immune system?  
 YES  No

Have you had an allergic reaction to Bananas?  YES  No

Do you smoke or chew tobacco?  YES  No

Have you had Heart Surgery?  YES  No

Are you now under the care of an MD?  YES  No

Are you taking or have you ever taken bisphosphonates?  
 (Fosamax or Actonel for osteoporosis, chemotherapy, etc)  YES  No

**FOR WOMEN ONLY:**

Are you taking birth control pills?  YES  No

Are you nursing/breastfeeding?  YES  No

Are you pregnant?  YES  No

Expected delivery date: \_\_\_\_\_

Is there a possibility of pregnancy?  YES  No

**NOTE:** Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

**Dental History Information**

Date of last dental visit? \_\_\_\_\_

Do you snore?  YES  No

Reason for today's visit? \_\_\_\_\_

Do you have problems with bad breath?  YES  No

\_\_\_\_\_

Have you ever had an allergic reactions to a crown, metal filling or dental appliance?  YES  No

Have you ever had an oral cancer screening?  YES  No

Have you ever used an electric toothbrush?  YES  No

How often do you floss your teeth? \_\_\_\_\_

Are your teeth sensitive to hot, cold or pressure?  YES  No

Do your gums bleed when you brush?  YES  No

Have you or a family member ever been treated for periodontal disease?  YES  No

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

1    2    3    4    5    6    7    8    9    10

Have you ever had complications from an extraction?  YES  No

If you could change something about your smile what would it be:

Have you ever had a popping or clicking near your ear when you chew?  YES  No

Whiter

Are you prone to frequent headaches?  YES  No

Straighter

Do you grind or clench your teeth?  YES  No

Close space

Do you have sores, blisters or swelling on your gums lips or cheeks?  YES  No

replace black mercury filling with tooth colored restorations

repair chipped teeth

replace missing teeth

less gums showing

Have you ever had orthodontic treatment?  YES  No

replace old crowns or caps that don't match

I certify that I have read and understand the questions, above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Adult/Guardian: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian (if patient is a minor): \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Dr. Signature: \_\_\_\_\_ Date: \_\_\_\_\_