

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Home Address _____ City _____ State _____ Zip _____

Home Phone # (_____) _____ Work Phone # (_____) _____

Employer _____ Date of Birth _____ Social Security # _____

Name of Spouse _____ Spouse's Birthdate _____

Spouse's Employer _____ Spouse's Social Security # _____

Name of Dental Insurance _____ Group Plan Number _____

Person Financially Responsible _____ Relationship _____

Billing Address _____

Name to call in case of emergency _____ Phone # (_____) _____

Whom may we thank for referring you _____

Former Dentist _____

Physician's Name _____ Phone # (_____) _____

Are you on a special or prescribed diet? yes no If yes, please explain: _____

How many soft drinks do you have per day? _____ coffee/tea _____ sugar? _____

If you smoke, how many cigarettes/cigars/pipes per day? _____

Have you ever used nitrous dental gas? yes no Do you want to use it for dental work? yes no

How long since your last dental visit? _____ What was done? _____

Why did you decide to change dentist? _____

Have you had an unfavorable dental visit? _____

Have you lost any of your natural teeth? yes no If yes, how? _____

Have they been replaced? yes no

Are you happy with the appearance of your teeth? yes no If not, why? _____

Name of Physician _____

Most recent Physical _____

Current weight _____ height _____

List any medications, herbal supplements, and/or vitamins taken within the last two years: _____

Please describe any current medical treatment, impending surgery, or other treatment that may affect your dental treatment: _____

Have you noticed in your mouth any of the following (check all that apply):

- Mouth sores that do not heal?
- Cold sores on lips?
- Growth, swelling, sore spots?
- Pain or tenderness in your teeth?
- Bleeding gums?
- Food catching between the teeth?
- Bad breath?
- Teeth that feel loose?

Have you had or been aware of any of the following (check all that apply):

- Tired feeling in your face while chewing?
- Ringing or pain in your ear?
- Pain around your ears, eyes, head or neck?
- Clenching and/or grinding teeth?
- Headaches?
- Difficulty in swallowing?

Please select an answer for each of the following:

Are you allergic to any of the following?

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin |
| <input type="checkbox"/> | <input type="checkbox"/> | Ibuprofen (Advil) |
| <input type="checkbox"/> | <input type="checkbox"/> | Acetaminophen (Tylenol) |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin/Amoxicillin/Ampicillin |
| <input type="checkbox"/> | <input type="checkbox"/> | Erythromycin |
| <input type="checkbox"/> | <input type="checkbox"/> | Tetracycline |
| <input type="checkbox"/> | <input type="checkbox"/> | Codeine |
| <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics |
| <input type="checkbox"/> | <input type="checkbox"/> | Fluoride |
| <input type="checkbox"/> | <input type="checkbox"/> | Metals (gold, stainless steel, _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex |
| <input type="checkbox"/> | <input type="checkbox"/> | Any other medication _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you required to take antibiotic pre-medication before dental treatment? If yes, for what condition _____ |

Please select an answer for each of the following:

Do you have any of the following conditions?

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart problems (surgery, disease, attack) |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | History of a stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial prosthesis (heart valve or joints) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Prolonged bleeding due to slight cut |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaundice |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid or parathyroid disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes (<input type="checkbox"/> Insulin <input type="checkbox"/> Diet controlled) |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Digestive disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or convulsions (seizures) |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis (type _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation therapy (head or neck) |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Tumor or abnormal growth |
| <input type="checkbox"/> | <input type="checkbox"/> | Any lumps or swelling in the mouth |
| <input type="checkbox"/> | <input type="checkbox"/> | Hives, skin rash, hay fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol or drug dependency |
| <input type="checkbox"/> | <input type="checkbox"/> | Emotional problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Antidepressant medications |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting/dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you presently being treated for any illness _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Aware of changes in your general health |
| <input type="checkbox"/> | <input type="checkbox"/> | Steroid/Cortisone in the last 2 years |
| <input type="checkbox"/> | <input type="checkbox"/> | Often exhausted or fatigued |
| <input type="checkbox"/> | <input type="checkbox"/> | Subject to frequent headache |
| <input type="checkbox"/> | <input type="checkbox"/> | Heavy smoker (1 or more packs a day) |
| <input type="checkbox"/> | <input type="checkbox"/> | Head or neck injuries |
| <input type="checkbox"/> | <input type="checkbox"/> | Any disease/condition not listed _____ |

I certify that I have read and understand the above and will not hold my dentist or his staff responsible for any errors or omissions in completion of this form.

Signature: _____ Date: _____

Permission is given to perform necessary dental work on myself/ for my child.