

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name) Gender: _____ Family Status: _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Cell): _____ (Work): _____ Ext: _____
Preferred appointment times: Morning Afternoon Any Time T W Th F
Email: _____
Address: _____
Street Apartment #
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| _____ | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Mitral Valve prolapse | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid condition | |

Have you ever been told that you need to take antibiotics prior to dental treatment? Yes No
If yes, why? _____

• What brings you to our dental office today?

Routine? YES ___ or other? _____

Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

Have you had any tooth pain recently? _____ If yes, where is it located? _____

Have you had any loose teeth or broken fillings that you are aware of? _____ If yes, where are they located? _____

Have you had periodontal treatment or been told that you have periodontal disease (gum disease) in the past? _____

Name of periodontist, if known: _____

Have you had orthodontic (braces) treatment in the past or currently? _____

Name of orthodontist, if current: _____

Are you satisfied with the appearance of your teeth? _____

Do you use cigarettes, cigar or other tobacco? YES or NO

If yes, how many packs per day, what type, and for how long? _____

Do you have any sores in your mouth that you are aware of? YES or NO If yes, where is it located?

Is there anything else about your dental treatment that you would like us to know?

- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian Date: _____

Medications: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _«HPhone»_____ (Work): _____ Ext: _____ Best time to call: _____

Address: _«Street»«Street2»_____ Apartment # _____
Street City«City» State «State» Zip «Zip»

In Case of emergency contact: _____
Relationship: _____ ***Phone:*** _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

