PATIENT INFORMATION

Date _____

Name (Last, First, Middle) _____ ☐ M ☐ S ☐ D ☐ W
Preferred Name _____ S.S. # _____ Birthdate _____
Home Address _____
City, State, Zip _____ Email _____
Home Phone _____ Work Phone _____ Cell Phone _____
Person Responsible for this Account _____ S.S. # _____
Employer _____ Dental Insurance Co. _____
Do you have a secondary insurance company? ☐ Yes ☐ No
Has any member of your family ever been treated in our office? ☐ Yes ☐ No
Who referred you to our office? _____ Would you like our monthly newsletter? ☐ Yes ☐ No

FAMILY INFORMATION

☐ Spouse ☐ Parent

Name (Last, First, Middle) _____ Home Phone _____
Home Address _____ Work Phone _____
City, State, Zip _____ Employer _____

MEDICAL HISTORY

Please check appropriate response and provide additional detail when applicable.

Medical doctor's name _____
Are you under a doctor's care now? ☐ Yes ☐ No If yes, why? _____
Have you been hospitalized during the past two years? ☐ Yes ☐ No If yes, why? _____
Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, list _____
Are you allergic to any medications or substance? ☐ Yes ☐ No If yes, what? _____
Are you allergic to latex? ☐ Yes ☐ No

For Women: Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No

Please check if you have ever had any of the following:

Scarlet Fever	Cancer	Hypoglycemia	Mitral Valve Prolapse	Osteoporosis
Heart Trouble	Chest Pain	Asthma	Thyroid Disease	Psychiatric Care
High Blood Pressure	Shortness of Breath	Hay Fever	Parathyroid Disease	Drug Addiction
Low Blood Pressure	Swelling of Feet/Ankles/Hands	Sinus Trouble	X-ray or Cobalt Tmt.	Blood Transfusion
Heart Murmur	Fainting or Dizziness	Emphysema	Chemotherapy/Radiation	Hemophilia
Rheumatic Fever	Stroke	Frequent Cough	Arthritis/Gout	AIDS
Congenital Heart Lesion	Diabetes	Lung Disease	Rheumatism	Venereal Disease
Artificial Heart Valve	Excessive Thirst	Tuberculosis	Pain in Jaw Joints	Cold Sores
Heart Pacemaker	Artificial Joints/Hips	Liver Disease	Cortisone Medicine	Fever Blisters
Heart Surgery	Kidney Trouble	Hepatitis A (infec.)	Glaucoma	Herpes
Blood Disease	Ulcers	Hepatitis B (serum)	Epilepsy or Seizures	Bruise Easily
Anemia	Allergies	Yellow Jaundice	Nervousness	Sickle Cell Anemia

Have you ever had any other serious illness not checked above? ☐ Yes ☐ No If yes, what? _____

DENTAL HISTORY

Please check appropriate response and provide additional detail when applicable.

Do you have a specific dental problem? ☐ Yes ☐ No If yes, describe _____
Do you think you have active decay? ☐ Yes ☐ No ☐ Don't know
Do you think you have gum disease? ☐ Yes ☐ No ☐ Don't know
Have you had gum treatment? ☐ Yes ☐ No
Have you had orthodontic treatment? ☐ Yes ☐ No
Have your parents experienced gum disease? ☐ Yes ☐ No ☐ Don't know
Did/do your parents wear dentures? ☐ Yes ☐ No ☐ Don't know

Do you have a regular dental examination? ☐ Yes ☐ No
When was your last dental examination? _____
Was a complete set of x-rays taken during your last examination? ☐ Yes ☐ No ☐ Don't know
Have you ever had professional instruction on home care? ☐ Yes ☐ No
How often do you usually have your teeth cleaned? _____
Name of previous dentist (optional) _____
Do you brush daily? ☐ Yes ☐ No If yes, ☐ Once ☐ Twice ☐ More than twice daily
Do you floss? ☐ Very often ☐ Often ☐ Seldom ☐ Never
Do you smoke tobacco? ☐ Yes ☐ No If yes, how much a day? _____
Do you chew tobacco? ☐ Yes ☐ No If yes, how much a day? _____
Are your teeth sensitive to: hot or cold? ☐ Yes ☐ No sweets? ☐ Yes ☐ No
brushing? ☐ Yes ☐ No biting or chewing? ☐ Yes ☐ No

DENTAL HISTORY (cont.)

Does food tend to become caught between your teeth? ☐ Yes ☐ No
Does your gum bleed when you brush? ☐ Yes ☐ No
Are you a mouth breather? ☐ Yes ☐ No ☐ Don't know
Do you chew on both sides of your mouth? ☐ Yes ☐ No ☐ Don't know
If you are wearing a removable partial or denture, are you aware of other options to replace missing teeth? ☐ Yes ☐ No
Does your jaw click or pop? ☐ Yes ☐ No
Is it painful when you open and close your jaw? ☐ Yes ☐ No
Do you grind or clench your teeth while awake? ☐ Yes ☐ No
Do you grind or clench your teeth while asleep? ☐ Yes ☐ No ☐ Don't know

Have you fainted at a dental visit before? ☐ Yes ☐ No
Do you feel very nervous about dental treatment? ☐ Yes ☐ No ☐ Somewhat
Have you had difficulty in getting your teeth numbed? ☐ Yes ☐ No
Have you ever had an upsetting experience in a dental office? ☐ Yes ☐ No If yes, please describe so we make sure this will not happen again. _____

_____

What did you like the most from your past dental experience? _____

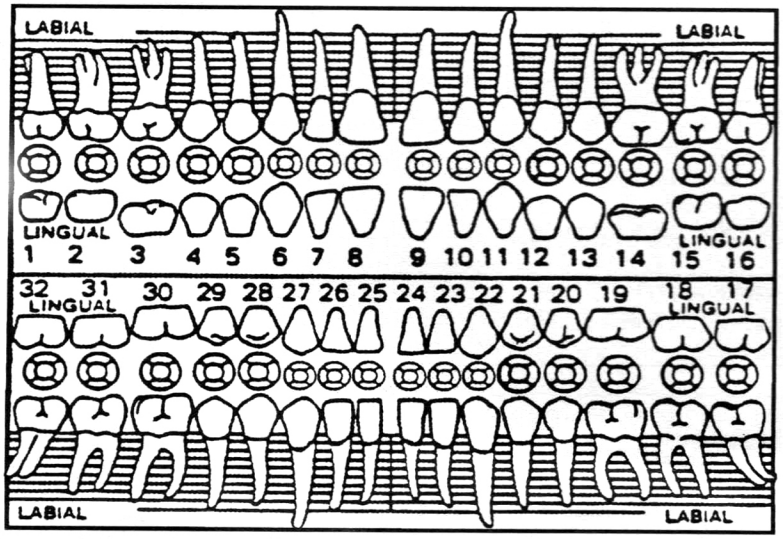
_____

How do you rate the appearance of your teeth in general? ☐ Excellent ☐ Good ☐ Fair ☐ Could be better
Would you like to improve the appearance of your teeth (whiter, straighter, Invisalign clear braces, smile makeover, etc.)? ☐ No ☐ Like to know more
Are you concerned with your breath? ☐ No ☐ Occasionally ☐ Always
Do you snack often? ☐ Yes ☐ No
Do you drink coffee or soft drinks throughout the day? ☐ Yes ☐ No

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the dental office of any changes in my medical status. I also have read and accept the financial policy of this office.

Signature_____ Date _____

GUM INFLAMMATION	N	L	M	S		RECESSION	N		FRENUM PULL
PLAQUE	N	L	M	S		ATTACHMENT	N		
STAIN	N	L	M	S		EXOSTOSIS	N		
TARTAR ABOVE	N	L	M	S		TOOTH COLOR	G		A
TARTAR BELOW	N	L	M	S		MOBILITY	N		
BITE & WEAR	NORMAL		L			M			S
			X-BITE		OVERBITE	OVERJECT			NIGHTGUARD
			CROWDED			SPACED			ABRASION
JAW JOINTS	NORMAL		NOISE			PAIN			HEADACHE
CANCER SCREENING	NORMAL		LYMPH		LIPS	CHEEK			FLOOR OF MOUTH
			TONGUE			ROOF OF MOUTH			THROAT



PERIODONTAL DX: NORMAL GINGIVITIS M S
PERIODONTAL DISEASE: INITIAL M S