WELCOME Our Dental Health Team appreciates the opportunity to serve you!

We are eager to assist you in establishing optimal oral health. Our goal is to help you keep your oral conditions in maximum comfort, function and appearance. We welcome your questions, comments and referrals.

TELEPHONE _____

Home Work Ext.

PERSONAL Name: _____ Male ☐ Female ☐

LAST FIRST MIDDLE INITIAL

Birthdate SS# Married ☐ Widowed ☐ Divorced ☐ Single ☐

HOME	**WORK**
Street Address or P.O. Box	Occupation How Long
City State Zip Code	Name of Employer Work Phone
Spouse or Parent	Employer's Address
Person Responsible for Account	City State Zip Code
Name (If Different from Above)	**SPOUSE**
Address	Occupation Daytime Phone
City State Zip Code	Employer

PURPOSE Purpose of today's visit _____

REFERRAL

Whom may we thank for referring you to our office?

Name _____

Address _____

EMERGENCY In Case of Emergency ....

Please Contact:

Name _____

Address _____

Phone _____

DENTAL INSURANCE Do you have Dental Insurance coverage? ☐ YES ☐ NO
If Yes, please complete following information.

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

_____

Insured's Employer _____

Insured's SS# _____ Group # _____ Local # _____

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

_____

Insured's Employer _____

Insured's SS# _____ Group # _____ Local # _____

I hereby give permission to assign Dental Insurance Benefits _____

PERSONAL DATA	All information will be kept confidential.	Adult ☐ Child ☐	Date

(Over)

INSTRUCTIONS: Please answer all questions accurately and in as much detail as possible. The completeness of your answers directly affect the diagnostic decisions made on your behalf. Your confidentiality will be respected.

Physician:_____ Phone Number: _____ Date of Last Visit: _____

GENERAL	YES	NO	COMMENTS
1. Are you in good health?	☐	☐	
2. Are you now under the care of a physician?	☐	☐	
3. Have you ever been hospitilized or had a serious illness?	☐	☐	
4. (Women) Are you pregnant or suspect you may be?	☐	☐	
5. Do you take birth control pills?	☐	☐	
6. Do you use any type of tobacco?	☐	☐	

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

EYES	YES	NO
Glaucoma	☐	☐
EARS		
Ringing in ears	☐	☐
NOSE		
Frequent nose bleeds	☐	☐
Sinus problems	☐	☐
THROAT		
Snoring	☐	☐
Soreness/hoarseness	☐	☐
NERVOUS SYSTEM		
Stroke	☐	☐
Headaches	☐	☐
Convulsions/epilepsy	☐	☐
Numbness/tingling	☐	☐
Dizziness/fainting	☐	☐
Psychiatric treatment	☐	☐
RESPIRATORY		
Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma/hay fever	☐	☐
Difficulty breathing while lying down	☐	☐

ENDOCRINE	YES	NO
Diabetes	☐	☐
Family history of diabetes	☐	☐
Thyroid condition/goiter	☐	☐
Other _____	☐	☐
HEART/BLOOD VESSELS		
Rheumatic fever	☐	☐
Heart murmur	☐	☐
Mitral Valve Prolapse	☐	☐
Chest pain/discomfort	☐	☐
Heart attack/trouble	☐	☐
Shortness of breath	☐	☐
High blood pressure	☐	☐
Congenital heart disease	☐	☐
Artificial heart valve	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐
BONE/MUSCLE/JOINTS		
Arthritis/rheumatism/joint pain	☐	☐
Artificial joint replacements	☐	☐

DIGESTIVE SYSTEM	YES	NO
Hepatitis	☐	☐
Jaundice	☐	☐
Ulcers	☐	☐
URINARY		
Kidney disease	☐	☐
Venereal disease (herpes syphyllis, gonorrhea, clymadia)	☐	☐
BLOOD		
Hemophillia	☐	☐
Bruise easily	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
OTHER		
AIDS/HIV	☐	☐
Radiation therapy	☐	☐
Tumors or growths	☐	☐
Cancer	☐	☐
Chemical Depend./Alcoholism	☐	☐
Latex Allergy	☐	☐
Fever Blister	☐	☐

MEDICATIONS: Please list all medications you are currently taking, the condition for which it was prescribed and dosage.

	MEDICATION	PURPOSE	DOSAGE
1.			
2.			
3.			
4.			

ALLERGIES — Please list all medicines or substances that you are allergic to: _____ _____ NONE ☐

MEDICAL ALERT

Former Dentist: _____ Location: _____ Last X-Rays: _____

Date of Last Visit: _____ Purpose of Visit: _____

GENERAL	**YES**	**NO**	**COMMENTS**
1. Are you having **problems** in your mouth?	☐	☐	
2. Are you **pleased** with your present **dental health** and the **appearance** of your teeth**?**	☐	☐	
3. Are you **apprehensive** about dental treatment?	☐	☐	
4. Are your teeth **sensitive** to hot, cold, sweets or pressure?	☐	☐	
5. Do you **grind** or **clench** your teeth?	☐	☐	
6. Are you aware of any **sores** or **lumps** in or near your mouth?	☐	☐	
7. Have you experienced any problems with your **jaws** or have **difficulty chewing?**	☐	☐	
8. Have you had any **orthodontic** work?	☐	☐	
9. Do you have any **bleeding** or **sore gums?**	☐	☐	
10. Have you had any **periodontal** (gum) **treatments?**	☐	☐	

MEDICAL/DENTAL HEALTH HISTORY

PATIENT SIGNATURE DATE