

WELCOME

Please take a few minutes to fill out this form. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

1 PATIENT INFORMATION

Preferred Name _____

Patient: Mr., Mrs., Ms., Miss, _____
FIRST INITIAL LAST

Address _____
STREET CITY STATE ZIP

Home Phone _____ Cell Phone _____

Email Address _____

Gender: M _____ F _____ Marital Status: Single _____ Married _____ Other _____

Social Security Number _____ Birthdate _____

Occupation _____ Employer _____ Work Phone _____

Work Address _____
STREET CITY STATE ZIP

Spouse's Name _____ Spouse's Work Phone _____

Emergency Contact Phone Number (Home) _____ Emergency Contact Phone Number (Cell) _____

Please tell us how you found our office (Optional) _____

2 DENTAL HISTORY

Please place a mark on the "Yes" or "No" box next to each item to indicate if you have had any of the following conditions:

| YES | NO | | YES | NO | | YES | NO | |
|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Bad Breath (Halitosis) | <input type="checkbox"/> | <input type="checkbox"/> | Loose Teeth | <input type="checkbox"/> | <input type="checkbox"/> | Smokeless Tobacco Habit |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Gums | <input type="checkbox"/> | <input type="checkbox"/> | Missing Teeth | <input type="checkbox"/> | <input type="checkbox"/> | Smoking Habit |
| <input type="checkbox"/> | <input type="checkbox"/> | Blisters on Lips or in Mouth | <input type="checkbox"/> | <input type="checkbox"/> | Mouth Breathing | <input type="checkbox"/> | <input type="checkbox"/> | Sores in Your Mouth |
| <input type="checkbox"/> | <input type="checkbox"/> | Broken or Chipped Teeth | <input type="checkbox"/> | <input type="checkbox"/> | Orthodontic Treatment (Braces) | <input type="checkbox"/> | <input type="checkbox"/> | Spaces Between Teeth |
| <input type="checkbox"/> | <input type="checkbox"/> | Burning Sensation in Mouth | <input type="checkbox"/> | <input type="checkbox"/> | Periodontal (Gum) Treatment | <input type="checkbox"/> | <input type="checkbox"/> | Stains on Teeth |
| <input type="checkbox"/> | <input type="checkbox"/> | Clicking or Popping in Jaw Joint | <input type="checkbox"/> | <input type="checkbox"/> | Sensitive Teeth/Gums | <input type="checkbox"/> | <input type="checkbox"/> | Swollen or Tender Gums |
| <input type="checkbox"/> | <input type="checkbox"/> | Dark Teeth | <input type="checkbox"/> | <input type="checkbox"/> | to Biting/Chewing | <input type="checkbox"/> | <input type="checkbox"/> | Teeth Moving |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry Mouth | <input type="checkbox"/> | <input type="checkbox"/> | to Brushing | <input type="checkbox"/> | <input type="checkbox"/> | TMD/TMJ Treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Grinding or Clenching Teeth | <input type="checkbox"/> | <input type="checkbox"/> | to Cold | <input type="checkbox"/> | <input type="checkbox"/> | Trauma or Injury to Teeth, |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> | to Heat | <input type="checkbox"/> | <input type="checkbox"/> | Jaws or Face |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw or Joint Pain | <input type="checkbox"/> | <input type="checkbox"/> | to Sweets | | | |

Date of last dental visit _____

Do you have any concerns about your teeth or mouth? _____

Is there anything you would like to change about the appearance of your teeth? _____

3 HEALTH HISTORY

Please place a mark on the "Yes" or "No" box next to each item to indicate if you have had any of the following conditions:

| Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina (chest pain) | <input type="checkbox"/> | <input type="checkbox"/> | Heart Problem | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of Breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis, Rheumatism | <input type="checkbox"/> | <input type="checkbox"/> | Heart Valve Replacement | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problem |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis, type _____ | <input type="checkbox"/> | <input type="checkbox"/> | Skin Rash |
| <input type="checkbox"/> | <input type="checkbox"/> | Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | Herpes | <input type="checkbox"/> | <input type="checkbox"/> | Stroke or TIA |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Problem | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Disease | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> | Swelling of Feet or Ankles |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Swollen Neck Gland |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemical Dependency | <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problem |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Circulatory Problem | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | Tobacco Habit, |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Tumor |
| <input type="checkbox"/> | <input type="checkbox"/> | Cortisone Treatment | <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Nervous Problem | <input type="checkbox"/> | <input type="checkbox"/> | Weight Loss or Gain |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker | | | Women: |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Care | <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting or Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Treatment | | | Due Date _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problem | <input type="checkbox"/> | <input type="checkbox"/> | Are you nursing? |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Do you take birth control pills? |

Primary Physician _____ Phone _____ Date of Last Visit _____

4 ALLERGIES

Please place a mark on the "Yes" or "No" box next to each item to indicate if you have had an allergic reaction to any of the following:

| Yes | No | | Yes | No | | Yes | No | | |
|--------------------------|--------------------------|-------------|--------------------------|--------------------------|---------|--------------------------|--------------------------|------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> | Codeine | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetic | |
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> | Latex | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin | |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ | (Please Explain) _____ | | | | | | |

5 MEDICATIONS

Please list all of the prescription medications you are currently taking with the dosages if you know them.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list any over-the-counter medications, vitamins, dietary or herbal supplements, etc. that you are taking.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Pharmacy Name _____ Phone _____

6 AUTHORIZATION

The information I have given is correct to the best of my knowledge. I understand that it is my duty to inform this office of any change in my health or medical status and that such changes may effect my dental care.

I understand that I am financially responsible for all charges and that payment in full is expected at the time of treatment unless prior financial arrangements have been made. I recognize that any dental insurance coverage I have is a separate arrangement between me and a third party who may or may not reimburse a portion of my expenses.

Signature _____ Date _____