

Patient Information

Patient Name: _____ Date: _____
Last First MI
 Male Female Married Single Child Other _____ Birth Date: _____
Social Security #: _____ Driver's License # _____ State _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
E-Mail: _____ Fax: _____ Mobil/Cell _____
Address: _____
Street Apartment #
City State Zip Code

Health Information

Previous Dentist: _____ 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"/> Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Latex Sensitivity | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Psychiatric/Psychological Care | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> H. I. V. Positive | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Allergic/Adverse Reaction To |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart (Attack, Disease, Surgery) | <input type="checkbox"/> Radiation Treatment | Medication or Any Substance, Please |
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | specify: _____ |
| <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatism | _____ |
| <input type="checkbox"/> Diet (Special/Restricted) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Smoke/Chew Tobacco | |

- Have you ever had any complications following dental treatment? Yes No If yes, please explain: _____
- 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: _____
- Are you taking any medications? Purpose? Please list _____

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 doctor at the next appointment without fail.

Signature of patient, parent or guardian Date: _____

Signature of Doctor Date: _____

Cosmetic Information

Do you like the appearance of your teeth? _____

Is there anything about your smile that you do not like? _____

Would you like your teeth to be whiter? _____

Are all of your teeth in alignment (straight)? _____

Do you have any missing teeth? _____ Are any chipped? _____

Is your bite comfortable when chewing, biting? _____

Do you have frequent headaches? _____

Do your gums ever bleed? _____

Do you have any old fillings or dental treatment that you are unhappy with? _____

Do you use products such as mints, mouth rinse or chewing gum to help maintain fresh breath? _____

Are you interested in learning more about professional breath control? _____

Is there anything else that you would like us to know? _____

Referral Information

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

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

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: _____ Driver's License #: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street

Apartment #

City

State

Zip Code

Employment Information

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

Employer Name: _____ Occupation: _____

Address: _____

Street

City

State

Zip Code

