PATIENT INFORMATION

Patient Name: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Employer: _____

Email: _____

Soc. Sec. #: _____

Referred by: _____

Today's Date: _____

Date of Birth: _____

Insurance Co: _____

Insurance Address: _____

Insurance Subscriber: _____

Subscriber Soc. Sec. #: _____

Subscriber Birthdate: _____

Group #: _____

Medical History

Physician Name: _____

Office Phone: _____

Date of Last Exam: _____

Please list any prescription or non-prescription medications that you are currently taking?

_____ _____

_____ _____

_____ _____

Women Only:

Yes	*No*	
❑	❑	Are you pregnant or think you may be pregnant? If yes, please list Ob/Gyn name and phone: _____
❑	❑	Are you nursing?
❑	❑	Are you taking Birth Control Pills?

Yes	*No*	
❑	❑	Are you under any medical treatment now?
❑	❑	Have you ever been hospitalized?
❑	❑	Have you had surgery in the past?
❑	❑	Do you or have you ever smoked? #packs/day _____ # years_____
❑	❑	Do you use chewing tobacco or snuff?
❑	❑	Do you wear contact lenses?
❑	❑	Do you take aspirin or blood thinners?
❑	❑	Have you ever had a reaction to local anesthetic (Novocaine)?
❑	❑	Are you allergic to Penicillin?
❑	❑	Do you have allergies to any other medications? Please List: _____

Do you have or have you had any of the following?

Yes	*No*		
❑	❑	High Blood Pressure	_____
❑	❑	Heart Disease	_____
❑	❑	Heart Attack	_____
❑	❑	Heart Murmur	_____
❑	❑	Mitral Valve Prolapse	_____
❑	❑	Angina/Chest Pain	_____
❑	❑	Rheumatic Fever	_____
❑	❑	Heart Valve Replacement	_____
❑	❑	Cardiac Pacemaker	_____
❑	❑	Tuberculosis	_____
❑	❑	Respiratory Problems	_____
❑	❑	Asthma	_____
❑	❑	Emphysema	_____
❑	❑	Liver Disease	_____
❑	❑	Hepatitis/Jaundice	_____
❑	❑	Kidney Disease	_____
❑	❑	Dialysis	_____
❑	❑	Diabetes	_____
❑	❑	Thyroid Problem	_____

Yes	*No*		
❑	❑	Blood Disease	_____
❑	❑	Leukemia	_____
❑	❑	Anemia	_____
❑	❑	Stroke	_____
❑	❑	Psychiatric Disorder	_____
❑	❑	Epilepsy/Seizures	_____
❑	❑	Fainting	_____
❑	❑	Depression	_____
❑	❑	Cancer	_____
❑	❑	Radiation Therapy	_____
❑	❑	Chemotherapy	_____
❑	❑	Arthritis	_____
❑	❑	Joint Replacement	_____
❑	❑	Stomach Problems/Ulcers	_____
❑	❑	Hay Fever/Allergies	_____
❑	❑	Autoimmune Disease	_____
❑	❑	Glaucoma	_____
❑	❑	Sexually Trans. Disease	_____
❑	❑	HIV or AIDS	_____

DENTAL HISTORY

Date of Last Dental Exam: _____

Date of Last X-rays: _____

Yes	*No*	
❑	❑	Have you ever had any head, neck, or jaw injuries?
		Have you ever experienced any of the following problems with your jaw?
❑	❑	• Clicking
❑	❑	• Pain (joint, ear, side of face)
❑	❑	• Difficulty opening or closing
❑	❑	• Difficulty chewing
❑	❑	Do you have frequent headaches?
❑	❑	Do you clench or grind your teeth?
❑	❑	Do you need to or have you ever taken antibiotics before dental treatment?

Yes	*No*	
❑	❑	Do you have pain in any of your teeth?
❑	❑	Are your teeth sensitive to sweet or sour?
❑	❑	Are your teeth sensitive to hot or cold?
❑	❑	Do your gums bleed while brushing and flossing?
❑	❑	Have you ever been diagnosed with gum disease?
❑	❑	Have you ever had braces?
❑	❑	Do you have any sores or lumps in or near your mouth?
❑	❑	Have you had difficult extractions in the past?
❑	❑	Have you had prolonged bleeding following extractions?
❑	❑	Do you bite your cheeks or lips frequently?
❑	❑	Do you have dental implants?
❑	❑	Do you have a dry mouth?
❑	❑	Are you fearful of dental injections/dental treatment?
❑	❑	Do you have trouble sitting in the dental chair for more than an hour?

Smile Assessment

Yes	*No*	
❑	❑	Are you concerned about the appearance of your teeth or your smile?
❑	❑	Are you concerned about the whiteness/lack of whiteness or your teeth?
❑	❑	Are you concerned about the position or angle of one or more of your teeth?
❑	❑	Are you concerned about the shape of one or more of your teeth?
❑	❑	Are there things about your front teeth that you would like to change?
❑	❑	In social situations, are you embarrassed by your teeth or smile?
❑	❑	Do you have old fillings or previous dental treatment that is no longer satisfactory to you?
❑	❑	Is your bite uncomfortable when biting or chewing?
❑	❑	Do you have spaces or missing teeth?
❑	❑	Are you interested in learning more about esthetic dentistry?
❑	❑	Do you have any additional concerns that were not addressed on this form? If yes, please list:

_____

_____

_____

SIGNATURE

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X _____ _____

(Patient, Parent, or Guardian) DATE