



PATIENT INFORMATION

Today's Date: _____

First Name: _____ Middle Name: _____ Last Name: _____

Name that you prefer to be called: _____

Sex: M F Date of Birth: _____ Social Security Number: _____

Address: _____ City _____ State _____ Zip _____

Phone number: (h) _____ (c) _____ (w) _____

Email address: _____

Preferred method of communication: Phone call Text message Email

Marital status: M S W D Number of children: _____ Children's ages _____

Are you presently employed? Yes No Full time Part time Unemployed Disabled Retired

Occupation: _____ Employer: _____

What is the reason for seeing us today? _____

Who may we thank for referring you? _____

What can we do to ensure your experience with us is a pleasant one? _____

What was the reason you stopped seeing your previous dentist? _____

SUBSCRIBER EMPLOYMENT INFORMATION

The following is for: patient the insurance policy holder

Employer Name: _____ Phone: _____

Address: _____ City _____ State _____ Zip _____

Occupation: _____

SPOUSE OR SUBSCRIBER EMPLOYMENT INFORMATION

The following is for: patient's spouse the insurance policy holder

First Name _____ Middle Name _____ Last Name _____

Name that you prefer to be called: _____

Sex: M F Date of Birth: _____ Social Security Number: _____

Address: _____ City _____ State _____ Zip _____

Phone number: (h) _____ (c) _____ (w) _____

Email address: _____

DOCTOR HISTORY

Primary Care or Referring Physician (Name & Phone): _____

Previous Dentist (Name & Phone): _____

EMERGENCY CONTACTS

Emergency Contact (Name & Phone): _____

Emergency Contact (Name & Phone): _____

INSURANCE INFORMATION

Primary Dental Insurance

Insurance Name: _____ Phone #: _____

Subscriber Name: _____ Subscriber Employer: _____

Subscriber Social Security #: _____ Subscriber Date of Birth: _____

Group / Policy Number: _____

Is this an employer or union policy? _____

Secondary Dental Insurance

Insurance Company Name: _____ Phone # _____

Subscriber Name: _____ Subscriber Employer: _____

Subscriber Social Security #: _____ Subscriber Date of Birth: _____

Group / Policy Number: _____

Is this an employer or union policy? _____

Primary Medical Insurance

Insurance Company Name: _____ Phone # _____

Subscriber Name: _____ Subscriber Employer: _____

Subscriber Social Security #: _____ Subscriber Date of Birth: _____

Group / Policy Number: _____

Do you have secondary medical insurance? _____

MEDICAL HISTORY

Patient's Name: _____

Today's Date: _____

Date of Last Physical: _____ Weight: _____ Height: _____

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergies (seasonal) | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Nervous disorders |
| <input type="checkbox"/> Allergies to latex | <input type="checkbox"/> Fainting / dizzy spells | <input type="checkbox"/> Neurological disorder |
| <input type="checkbox"/> Allergies to medications (list below) | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Acid Reflux/ GERD | <input type="checkbox"/> Gall bladder problems | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Herpes | <input type="checkbox"/> Persistent cough |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Valve replacement | <input type="checkbox"/> Prosthetic joint |
| <input type="checkbox"/> Angina / Chest pain | <input type="checkbox"/> Head / neck trauma | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Psychological disorders |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Healing problems | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Headaches | <input type="checkbox"/> Radiation therapy |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Ringing in ears (Tinnitus) |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Cancer or tumors | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Immune system disorder | <input type="checkbox"/> STD |
| <input type="checkbox"/> Congenital heart condition | <input type="checkbox"/> Infective endocarditis | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Drug / Alcohol abuse | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Joint disease | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lupus | <input type="checkbox"/> Other |
| <input type="checkbox"/> Epilepsy / seizures | <input type="checkbox"/> Mitral valve prolapse | _____ |
| | <input type="checkbox"/> Neurological problems | _____ |

Do you have any allergies to medications?

Aspirin Codeine Erythromycin Tetracycline Penicillin Sulfa

Other allergies to medications (please list): _____

If you checked any of the above or have other medical conditions, please explain: _____

Number of alcoholic drinks per week: _____

Do you or have you ever smoked or used chewing tobacco? YES NO

If yes, how much and for how long? _____

Have you had a **heart attack or heart surgery (bypass/stent)** in the last 6 months? Yes No **Have you ever taken "bisphosphonates"** (Fosamax, Actonel, Aredia, or Pamidronate?) Yes No

Do you need to be pre-medicated with antibiotics for dental treatment? Yes No

Women Only:

Any chance you are pregnant? Yes No Are you nursing? Yes No

Are you taking birth control pills? Yes No

Please list ALL medications that you are currently taking:

I take no medications at this time

Medication	How often	For What	Amount taken	Doctor

I certify that the above is true to the best of my knowledge. I understand that if there are any changes to my health or medications, I will advise my dentist before beginning any treatment.

Patient **Name:** _____ **Today's Date:** _____

Patient Signature: _____

DENTAL HISTORY

Patient's Name: _____ Date: _____ Date of last dental exam: _____

Date of last cleaning: _____ How often do you brush? _____ How often do you floss? _____

Please check all that apply to you:

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Tooth removal | <input type="checkbox"/> Food gets stuck | <input type="checkbox"/> Accident in past | <input type="checkbox"/> Pain when chewing |
| <input type="checkbox"/> Tooth decay | <input type="checkbox"/> Braces | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Gum surgery | <input type="checkbox"/> Jaw surgery |
| <input type="checkbox"/> Broken teeth | <input type="checkbox"/> Sensitive teeth | <input type="checkbox"/> Toothache | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Hot / cold sensitive |
| <input type="checkbox"/> Wear of teeth | <input type="checkbox"/> Crowding of teeth | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Other: _____ | |

Are you happy with the way your teeth look? YES NO If not, why? _____

Are you dissatisfied with any of the following?

- | | | | | |
|---|---------------------------------------|--|--|-------------------------------------|
| <input type="checkbox"/> Shape of teeth | <input type="checkbox"/> Crowding | <input type="checkbox"/> Silver fillings | <input type="checkbox"/> Color | <input type="checkbox"/> Length |
| <input type="checkbox"/> Spacing | <input type="checkbox"/> Old fillings | <input type="checkbox"/> Misalignment | <input type="checkbox"/> "Gummy" smile | <input type="checkbox"/> Old crowns |
| <input type="checkbox"/> Bad bite | <input type="checkbox"/> Other | | | |

Do you have any sores / spots in mouth that haven't healed for more than 2 weeks? Yes No

Please check all that apply to you:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> TMJ problems | <input type="checkbox"/> Jaw clicking | <input type="checkbox"/> Pain in jaw | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Pain in facial area | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Tingling in fingers | <input type="checkbox"/> Dizziness (vertigo) |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Numbness in face | <input type="checkbox"/> Neck or back pain | <input type="checkbox"/> Jaw clenching |
| <input type="checkbox"/> Tightness in face | <input type="checkbox"/> Wear a night guard | <input type="checkbox"/> History of jaw lock | <input type="checkbox"/> Difficulty chewing |
| <input type="checkbox"/> Difficulty opening mouth | <input type="checkbox"/> Pain behind eyes | <input type="checkbox"/> Trigeminal neuralgia | <input type="checkbox"/> Bells Palsy |

Headache history: please check all that apply to you

Location of pain: Front of head / forehead Side of head Back of head

Intensity of pain: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (extreme pain)

Do you suffer from morning headaches? Yes No Sometimes

Do headaches wake you up from sleep? Yes No Sometimes

Do you have nausea with headaches? Yes No Sometimes

Frequency of headaches: Constant Once/day Once every few days Once/week

Sleep Apnea Assessment: please check all that apply to you

Have you ever been diagnosed with Sleep Apnea? Yes No If yes, when? _____

Diagnosing physician: _____ Name of sleep center? _____

Please check all that apply to you:

- | | | |
|---|--|---|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Gastro-esophageal reflux | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Gasping for air during sleep | <input type="checkbox"/> Feel tired in morning | <input type="checkbox"/> Poor concentration |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Difficulty breathing through nose | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Excessive daytime sleepiness |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Anxiety / depression | <input type="checkbox"/> Morning stiffness |

Have you ever used a CPAP device and could not tolerate it? Yes No

If you were not able to tolerate the CPAP, why? _____