Today's Date: ________________

First name: ______________________ MI: ____ Last name: ______________________ Nickname: ________________

Address: ____ City: _______________ ST: ______ Zip: ________

Home Phone: __________________ Cell Phone:__________________ E-mail Address: ________________________

Date of Birth: _______________ Social Security # ______________________ Drivers License # __________________

Are you a new patient? _________________ Referred by: ____

Employer: ______________________________Occupation: ____

Work Address: ______________________________________City: _________________ ST: ______ Zip: ______

Work Phone: ___________________ Extension: ______

Party Responsible for Account: ____

Spouse or Parents Name: ____

Names of Children: _______________ Age: ___, __________________ Age: ___, __________________ Age: ___

Address: (if Different) ____

Phone: _______________________ Date of Birth: ________________ Social Security # ______________________

Spouse's Employer: _____________________________________ Occupation: ______________________________

Spouse's Work Address: ______________________________ City: ______________ ST: _____ Zip: ____________

Spouse's Work Phone: ________________________ Extension: _______

Person to Contact for Emergency: ____

Address: ____City: _______________ ST:________ Zip: _______

Phone: __________________________

Closest Relative Not Living With You: ____

Address: ____City: _____________ ST: __________ Zip: ________

Phone: _________________________

Insurance Company (1): _____________________________ Group # ____________________________________

Subscriber Name: ____________________ Date of Birth: _________ Social Security # ________________

Address of Insurance: ____Phone#________________

Insurance Company (2): _____________________________ Group # ____________________________________

Subscriber Name: ____________________ Date of Birth: _________ Social Security # ________________

Address of Insurance: ____Phone#________________

Patient Name: ____________________________________ Date ______________________

Physician's Name: ________________________________
Physician's Address: ______________________________________ **Physician's Phone #** ________________
What is your present dental complaint: ____
____

DENTAL HISTORY

	YES	NO
Do you fear dental treatment………………………………………	☐	☐
Have you ever been treated for periodontal disease (pyorrhea)……	☐	☐
Have you ever had trench mouth…………………………………..	☐	☐
Do your gums bleed………………………………………………	☐	☐
Do you have difficulty chewing your food………………………..	☐	☐
Do you grind or clench your teeth…………………………………	☐	☐
Are spaces developing between your teeth………………………..	☐	☐
Have you noticed your bite changing……………………………...	☐	☐
Do you have pain in or near your ear………………………………	☐	☐
Do you get stress headache………………………………………..	☐	☐
Would you be interested in fresher breath…………………………	☐	☐
Do you have sores in your mouth …………………………………	☐	☐
Do you frequently breathe through your mouth…………………….	☐	☐
Have you ever had orthodontic treatment to straighten your teeth.	☐	☐

When was your last dental cleaning_______________________________
When were your last full mouth x-rays taken _______________________
Are any of your teeth sensitive to biting pressure ____________________
Are your teeth sensitive to Hot_____ Cold _______ Sweet _____
Have you had any "gum boils" or gum swelling ____________________
Are you satisfied with the appearance of your teeth __________________
If not, why not ____
How would you rate your past dental care Good __ Fair __ Poor __

Please note any items you use in mouth care and the frequency of their use:

Hand Toothbrush _______ Tooth Picks ______ Rubber Tip________

Dental Floss ______ Stimudents ______ Electric Toothbrush_______

Water Spray Device _____ Gum Stimulator _____ Proxabrush______

Toothpaste Type _______ Mouth washes ________ Other __________

MEDICAL HISTORY

Have You Ever Had:

	YES	NO
Hepatitis, Jaundice, or Liver Disease………………………………	☐	☐
Epilepsy, Convulsions, or Fainting Spells…………………………	☐	☐
Rheumatic Fever…………………………………………………..	☐	☐
Heart Murmur……………………………………………………..	☐	☐
Heart Trouble or Stroke…………………………………………..	☐	☐
High or Low Blood Pressure………………………………………	☐	☐
Shortness of Breath………………………………………………..	☐	☐
Chest Pains………………………………………………………..	☐	☐
Swelling in Ankles………………………………………………..	☐	☐
Tuberculosis………………………………………………………	☐	☐
Kidney disease or Infection………………………………………	☐	☐
Diabetes…………………………………………………………..	☐	☐
a. Auto Immune Disorder………………………….....	☐	☐
Arthritis or Rheumatism…………………………………………..	☐	☐
Stomach or Duodenal Ulcers……………………………………..	☐	☐
Do you wear contact lenses………………………………………	☐	☐
Hay fever………………………………………………………….	☐	☐
Medical Radiation Treatment……………………………………..	☐	☐
Glaucoma………………………………………………………….	☐	☐
Asthma…………………………………………………………….	☐	☐
Allergies………………………………………………………….	☐	☐
Drug Reaction to_____________________________________	☐	☐
Allergic to ____	☐	☐
Venereal disease………………………………………………….	☐	☐
Surgery…………………………………………………………….	☐	☐

	YES	NO
Abnormal Bleeding Problems………………………….	☐	☐
Anticoagulents (Blood Thinners)………………………	☐	☐
Nervous Breakdown……………………………………	☐	☐
Positive test for HIV/AIDS Virus………………………	☐	☐
Controlled Substance Use………………………………	☐	☐
Alcoholism……………………………………………...	☐	☐
Any Serious Illness Not Listed…………………………	☐	☐
ARE YOU:		
Presently under a physicians care………………………	☐	☐
Taking any medications now…………………………...	☐	☐
Or within past year…………………………	☐	☐
Allergic to Dental Anesthetic…………………………..	☐	☐
Aware of recent weight change…………………………	☐	☐
Often exhausted or fatigued…………………………….	☐	☐
Subject to frequent headaches…………………………..	☐	☐
A nervous person……………………………………….	☐	☐
Taking nerve or sleeping medication…………………..	☐	☐
Often unhappy or depressed…………………………….	☐	☐
Taking antidepressant medication……………………..	☐	☐
Do you bruise easily…………………………………….	☐	☐

If you smoke, how much _______________________________

If FEMALE, are you now (please check if yes)

Pregnant ☐ Taking anti-pregnancy drug ☐
Presently in menopause ☐ Post-menopause ☐

	YES	NO
Do you have problems with your menstrual cycle……..	☐	☐

Patient Signature: ____________________________ **Reviewed by:** _____________________ **Date:** ______

Comments:
____
____
____