Date: _____

Name: _____

Address: _____

City: _____

Sate: _____ Zip: _____

Phone Hm: _____ Wk: _____

Mobile: _____ Other: _____

Email: _____

Social Securtiy: _____

Driver's License: _____

Date of Birth: _____

Occupation: _____

Employer: _____

Address: _____

_____

Emergency Phone: _____

Name: _____

Person responsible for dental investment:

Name: _____

How did you hear about our office?

_____

Why did you leave your last dentist?

_____

What are your present dental problems?

_____

When was your last dental appointment?

For Insurance Purposes

Name of Insurance Co.: _____

Address: _____

Name of policy holder: _____

SSN of policy holder: _____

DOB of policy holder: _____

Employer of policy holder: _____

Are you covered by another dental plan? _____

If so, name of insurance: _____

Insurance Co Address: _____

SSN of policy holder: _____

DOB of policy holder: _____

Please answer the following

	Yes	No
Do you ever avoid any part of the mouth while brushing?	☐	☐
Are you dissatisfied with your teeth and their appearance?	☐	☐
Do your gums bleed while brushing?	☐	☐
Does food catch between your teeth?	☐	☐
Are your teeth sensitive to: Hot or cold? Sweets? Biting pressure?	☐ ☐ ☐	☐ ☐ ☐
Have you noticed any gum swelling between around your teeth?	☐	☐
Does your jaw click?	☐	☐
Do you feel you will eventually wear artificial dentures?	☐	☐
Are you deeply concerned about the finances required to return your mouth to excellent dental health?	☐	☐

If I could change my smile I would make my teeth:
whiter____straighter____repair chipped teeth____ close spaces

I think my present state of dental health is:
Excellent ____Good ____Poor

Does dental treatment make you nervous?
No____ Slightly ____ Moderate ____ Extremely

Patient Name _____

Sex _____ Age_____Height _____ Weight _____

Directions

Please circle the appropriate answer to the questions and fill in the blanks where indicated. Answer all questions and blanks completely. Answers to the following questions are for our records and will be considered confidential.

1.Are you in good health?.....Yes No

A. Has there been any changes in your general health?.....Yes No

2. My last physical examination was on _____

3. Are you now under the care of a physician?.....Yes No

If so, what is the condition being treated

_____

4. The name and address of your physician is:

_____

_____

5. Have you had a serious illness or operation?.....Yes No

If so, what is the illness or operation:

_____

6.Have you been hospitalized or had serious illness within the past five years.....Yes No

A. Do you have a persistent cough or cough up blood.....Yes No

B. Low blood pressure.....Yes No

C. Venereal disease.....Yes No

D. AIDS or HIV……Yes No

E. Other……Yes No

7. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma.....Yes No

A. Do you bruise easily……..Yes No

B. Have you ever required a blood transfusion.……Yes No

If so, explain the circumstances

_____

8. Do you have a blood disorder such as anemia……Yes No

9. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips……Yes No

10. Are you taking any drug or medication……..Yes No

11. Are you taking any of the following:

A. Antibiotics or sulfa drugs……..Yes No

B. Anticoagulants (blood thinners)……..……Yes No

C. Medicine for high blood pressure……..……Yes No

D. Cortisone (steroids)……..……Yes No

E. Tranquilizers……..……Yes No

F. Aspirin……..……Yes No

G. Insulin, Tolbutamide (Orinase) or similar drug……..Yes No

H. Digitalis or drugs for heart trouble……..…Yes No

I. Nitroglycerin……..Yes No

J. Fen-Phen (now or in the past)……..Yes No

K. Oral Contraceptives……..Yes No

L. If so, what are you using_____

M. Bisphosphonales (fosomax)……Yes No

N.Osteoporosis……Yes No

12. Do you have a heart murmur/mitral valve prolapse.…Yes No

13. Do you have any implants and/or prosthesis (i.e. knee joints, elbow pins, etc.)……..……Yes No

14. Do you drink alcoholic beverages……Yes No

15. Do you smoke……Yes No

If so, how much_____

16. Do you have or have you had any of the following diseases or problems:

A. Rheumatic fever or rheumatic heart disease……Yes No

B. Congenital heart lesions……Yes No

C. Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, stroke).....Yes No

1) Do you have pain in the chest upon exertion……..Yes No

2) Are you ever short of breath when you lie down or do you require extra pillows when you sleep……Yes No

D. Allergy……..Yes No

E. Asthma or hay fever……..Yes No

F. Hives or skin rash……..Yes No

G. Fainting spells or seizures……Yes No

H. Diabetes……Yes No

1) Does your mouth frequently become dry……..Yes No

I. Hepatitis, jaundice, or liver disease……Yes No

J. Arthritis……Yes No

K. Inflammatory rheumatism (painful, swollen joints)…….Yes No

L. Stomach ulcers……Yes No

M. Kidney trouble……..Yes No

N. Tuberculosis……..……Yes No

17. Are you allergic or have you reacted adversely to:

A. Local anesthetic……..Yes No

B. Penicillin or other antibiotics……Yes No

C. Barbiturates, sedatives, or sleeping pills……Yes No

D. Sulfa drugs……..Yes No

E. Aspirin……Yes No

F. Iodine……..Yes No

G. Latex……Yes No

H. Other:_____

18. Have you had any serious trouble associated with previous dental

treatment……..……Yes No

If so, explain_____

_____

19. Are you pregnant or could you be……Yes No

If so, when are you due_____

I certify to the best of my knowledge that the above information is correct and that if there are any changes in the above, I agree to notify my dentist before my next visit.

Patient/Guardian_____Date_____

Doctor_____Date_____

Updates:

Patient/Guardian_____Doctor_____Date_____

Patient/Guardian_____Doctor_____Date_____

Patient/Guardian_____Doctor_____Date_____

Patient/Guardian_____Doctor_____Date_____