



Welcome

About You

Today's Date: _____ E-mail Address: _____

Name: _____ I prefer to be called: _____ Male Female
Last First MI Mr. Mrs. Ms. Dr.

Birthdate: ___/___/___ Social Security #: _____ Single Married Divorced Widowed Separated

Home Address: _____
Street City State Zip

Home Phone: (____) _____ Cell/other: (____) _____ Work Phone: (____) _____ Driver's License #: _____

Whom may we thank for referring you? _____ Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Spouse Name: _____ Spouse Employer: _____ Spouse Work Phone: (____) _____

Emergency Contact (other than residence): _____

Relation: _____ Home Phone: (____) _____ Cell Phone: (____) _____

Insurance Information

Insurance Co. Name: _____ Phone #: (____) _____

Insured's Employer: _____ Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___

Dental History

Why have you come to the dentist today? _____

Are your teeth sensitive to heat, cold or anything else? _____

Are you happy with the way your smile looks? Yes No If not, what would you change? _____

Are you currently in pain? Yes No
Your current dental health is Good Fair Poor
Do you floss daily? Yes No Brush Daily? Yes No
Type of bristles on your toothbrush? Hard Medium Soft
Do your gums ever bleed? Yes No Ever Itch? Yes No
Have you ever had periodontal disease? Yes No

Do you still have wisdom teeth? Yes No
Would you like fresher breath? Yes No
Would you like whiter teeth? Yes No
Do you have mobility in your teeth? Yes No
Do you use tobacco? Yes No
Are you on a special diet? Yes No

Previous/Past Dentist: _____ Last Visit Date: _____

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

Are you under a physician's care now? Yes No If yes _____

Have you ever been hospitalized or had a major operation? Yes No If yes _____

Have you ever had a serious head or neck injury? Yes No If yes _____

Are you taking any medications, pills or drugs? Yes No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No

Do you use controlled substances? Yes No

Women: Are you... Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following? Aspirin Penicillin Codeine Tetracycline

Metal Latex Sulfa Drugs Dental Anesthetics

Other? If yes, _____

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

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Colitis	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Alcohol Abuse	<input type="radio"/> Yes <input type="radio"/> No	Cong. Heart Disease	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatment	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	Hives/Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy/Seizures	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sinus Problems	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Steroid Therapy	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Int. Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Light Sensitivity	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Lupus	<input type="radio"/> Yes <input type="radio"/> No	Tumors/Growths	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Heart Disease	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Valve Replace	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/F. Blisters	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No		

Have you ever had any serious illness not listed above? Yes No If yes, _____

Comments: _____

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need.

Signature of Patient, Parent or Guardian

Date