PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Child

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext. _____ (Cell): _____ (Pager): _____

Best Time to Call: _____ E-mail Address: _____

Address: _____
Street Apartment

_____
City State Zip Code

Occupation: _____ Employer's Name: _____

Business Address: _____
City State Zip Code

Spouse's Name: _____ Social Security #: _____ Bus #: _____

Spouse's Occupation: _____ Spouse's Employer: _____

Person to Contact in Case of an Emergency: _____

Relationship: _____ Home #: _____ Bus #: _____

Party Responsible for Payment of Account: _____

Home #: _____ Bus #: _____

Whom may we thank for referring you? _____

Reason for this visit: _____

DENTAL HISTORY

Your Last Dentist: _____ City: _____ How Long: _____

Date of Last Visit: _____ Date of Last Dental Cleaning: _____ Date of Last X-rays: _____

Check any of the following you have had or currently have:

- ☐ Mouth Discomfort
- ☐ Previous Periodontal Treatment
- ☐ Trenchmouth or Pyorrhea
- ☐ Gum Abscesses
- ☐ Gums Bleed When Brushing
- ☐ Loose or Shifting Teeth
- ☐ Trouble in Chewing or Speaking
- ☐ Bruise Easily
- ☐ Grind or Clench Teeth
- ☐ Clicking, Popping, or Pain in Jaw Joints
- ☐ Orthodontic Treatment
- ☐ Sensitive teeth (heat, cold, or sweets)
- ☐ Awake with Sore Jaws
- ☐ Mouth Odor or Bad Taste
- ☐ Cold Sores or Fever Blisters
- ☐ Other Oral Lesions
- ☐ Had immediate relatives lose all of their natural teeth
- ☐ Bad Dental Experience
- ☐ Complications with Previous Dental or Oral Surgical Treatment
- ☐ Fear of Dental Treatment

Additional Information: _____

_____

Do you snore? ☐ Yes ☐ No Do you have sleep apnea? ☐ Yes ☐ No

Do you use CPAP? ☐ Yes ☐ No Are you interested in an alternative to CPAP? ☐ Yes ☐ No

Is there anything you would like to change about your smile? _____

Would you like a free smile consultation? ☐ Yes ☐ No

Medical Health History

1. How would you describe your present health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
2. List your current Physician(s):
   a) _____ Type _____ How long? _____
   b) _____ Type _____ How long? _____
3. Date of last complete physical exam _____ Purpose _____
   Findings _____
4. Are you aware of any changes in your general health in the last year? ☐ Yes ☐ No
   Explain _____
5. Have you been hospitalized for illness or surgery in the past two years? ☐ Yes ☐ No
   Explain _____
6. Have you been under a medical doctor's care during the past two years? ☐ Yes ☐ No
   Explain _____
7. Have you ever had excessive bleeding that required special treatment? ☐ Yes ☐ No
   Explain _____
8. Is there any history of diabetes in your family? ☐ Yes ☐ No
   Explain _____
9. Are you required to restrict your work in any way? ☐ Yes ☐ No
   Explain _____
10. Are you on a special or restricted diet of any kind? ☐ Yes ☐ No
    Explain _____
11. Do you smoke? ☐ Yes ☐ No How much? _____ How long? _____
12. Do you use smokeless tobacco? ☐ Yes ☐ No How much? _____ How long? _____
13. List all the medications you are now taking (include all over-the-counter):
    _____
    _____
14. Please check any of the following medications you are allergic to:

☐ Penicillin	☐ Vibramycin	☐ Novacaine	☐ Tylenol	☐ Codeine	☐ Valium
☐ Erythromycin	☐ Sulfa Drugs	☐ Carbocaine	☐ Aspirin	☐ Demerol	☐ Barbiturates
☐ Tetracycline	☐ Keflex	☐ Xylocaine	☐ Anesthetics	☐ Morphine	☐ Vistaril

☐ Other _____

Indicate which of the following you have had or have at the present:

☐ Heart Trouble	☐ Artificial Joint (Knee, Hip)	☐ Cancers or Tumors
☐ Heart Disease or Attack	☐ Kidney / Bladder Trouble	☐ Radiation Treatment
☐ Angina	☐ Thyroid Disease	☐ Chemotherapy
☐ High Blood Pressure	☐ Emphysema	☐ Arthritis / Rheumatism
☐ Low Blood Pressure	☐ Persistent Cough	☐ Glaucoma
☐ Heart Murmur or Mitral Valve Prolapse	☐ Tuberculosis	☐ Contact Lenses
☐ Rheumatic Fever	☐ Asthma	☐ Hepatitis A, B, or C
☐ Congenital Heart Lesions	☐ Hay Fever	☐ Liver Disease
☐ Artificial Heart Valve	☐ Sinus Trouble	☐ Jaundice
☐ Scarlet Fever	☐ Allergies or Hives	☐ A.I.D.S. or HIV
☐ Heart Pacemaker	☐ Diabetes (Juvenile or Adult Onset)	☐ Blood Transfusion
☐ Heart Surgery	☐ Frequent Thirst and/or Urination	☐ Drug / Alcohol Addiction
☐ Shortness of Breath upon Mild Exertion	☐ Stroke	☐ Hemophilia
☐ Require More than Two Pillows to Sleep	☐ Epilepsy or Seizures	☐ Venereal Disease
☐ Ankles Swell	☐ Frequent Headaches	☐ A Nervous Person
☐ Sickle Cell Disease	☐ Fainting or Dizzy Spells	☐ Ulcers
☐ Head Injuries	☐ Unintentional Weight Gain / Loss	☐ Psychiatric Care

If Female, Are You: ☐ Pregnant? ☐ Taking Birth Control Pills? ☐ Through Menopause? ☐ Taking Hormone Medication?

Do you have any medical condition or diseases not listed above that we should know about? ☐ Yes ☐ No
Explain _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health, or if my medicines change, I will inform the doctor on or before my next appointment without fail.

_____ _____
Staff Signature Date Patient's Signature Date