Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name
LAST FIRST MI

Date Birth Date

SSN# – –

○ Male ○ Female ○ Married ○ Single ○ Child

Phone (Home)

Phone (Work) Best Time To Call

Address
STREET

CITY STATE ZIP

Do you have dental insurance? ○ Yes ○ No

Dental History

Other family members seen by us?

Current/Past Dentist?

What qualities do you look for in choosing a dentist?

What do you like most and least at other dental offices?

Why did you leave your last dental office?

If you could change anything about your smile, what would it be?

Reason for today's visit?

Describe your current health.

○ Yes ○ No Are you currently in pain?

If YES, describe.

○ Yes ○ No Do you ever have pain in your jaw joint?

○ Yes ○ No Do your gums ever bleed?

○ Yes ○ No Do you floss? How often?

○ Yes ○ No Do you brush? How often?

Type of bristles? ○ Hard ○ Med ○ Soft

○ Yes ○ No Any problems with past dental work?

If YES, describe.

Medical History

Chart # OFFICE USE ONLY

○ Yes ○ No Do you have a personal physician?

Dr's Name

Phone Date last visited

○ Yes ○ No Are you in good health?

If NO, why?

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

If YES, why?

○ Yes ○ No Are you taking any over-the-counter/prescription drugs?

If YES, list.

Do you have or ever had any of the following?

○ Yes	○ No	AIDS/HIV	○ Yes	○ No	Heart Surgery/Pacemaker
○ Yes	○ No	Artificial Joints	○ Yes	○ No	Mitral Valve Prolapse
○ Yes	○ No	Artificial Heart Valves	○ Yes	○ No	Rheumatic Fever
○ Yes	○ No	Anemia	○ Yes	○ No	Hemophilia/Ab. Bleeding
○ Yes	○ No	Arthritis/Rheumatism	○ Yes	○ No	Hepatitis-Type _____
○ Yes	○ No	Asthma/Allergies	○ Yes	○ No	Liver Disease
○ Yes	○ No	High Blood Pressure	○ Yes	○ No	Kidney Problems
○ Yes	○ No	Low Blood Pressure	○ Yes	○ No	Severe/Frequent Headaches
○ Yes	○ No	Blood Transfusion	○ Yes	○ No	Shingles
○ Yes	○ No	Cancer/Chemo/Radiation	○ Yes	○ No	Sinus Problems
○ Yes	○ No	Diabetes	○ Yes	○ No	Shortness of Breath
○ Yes	○ No	Drug/Alcohol Abuse	○ Yes	○ No	Smoke or Chew Tobacco
○ Yes	○ No	Emotional/Phychiatric Probs.	○ Yes	○ No	Tuberculosis
○ Yes	○ No	Emphysema	○ Yes	○ No	Ulcers/Colitis
○ Yes	○ No	Epilepsy/Siezures	○ Yes	○ No	Venerial Disease
○ Yes	○ No	Fainting Spells	○ Yes	○ No	Hospitalized for any reason? Please List.
○ Yes	○ No	Fever Blisters/Canker Sores			
○ Yes	○ No	Glaucoma			
○ Yes	○ No	Heart Problems	○ Yes	○ No	Any other medical condition? Please List.
○ Yes	○ No	Congenital Heart Defect			
○ Yes	○ No	Heart Attack/Stroke			
○ Yes	○ No	Heart Murmur			

If you answered YES to any question above, please explain.

Are you allergic to any the following?

○ Yes	○ No	Aspirin	○ Yes	○ No	Latex Gloves
○ Yes	○ No	Barbiturates (Sleep. Pills.)	○ Yes	○ No	Penicillin
○ Yes	○ No	Codeine	○ Yes	○ No	Sulfa Drugs
○ Yes	○ No	Dental Anesthetics	○ Yes	○ No	Any other Allergies? If YES, please list.
○ Yes	○ No	Erythromycin			

Women Only.

○ Yes ○ No Do you take birth control pills?

○ Yes ○ No Are you pregnant? If YES, due date?

○ Yes ○ No Are you nursing?