

PATIENT # _____

Personal Information

Name _____ Date of birth _____

Address _____
First MI Last City Zip

Phone (home) _____ (office) _____

SS# _____ Whom may we thank for your referral? _____

Check box: Minor Single Married Divorced Widowed Separated

Employer _____ Occupation _____ Years employed _____

Spouse Info Name _____ Address _____

Phone _____ Occupation _____ Employer _____

Responsible Party

Name _____ Address _____ Phone _____

Emergency notification info: Name _____ Phone _____

Address _____

General Medical Information

Have you been under physician's care in the past 12 months? Yes No

Are you taking any medications at this time? Yes No

Medications: _____

When was the last time you saw your physician? _____

Purpose of visit _____

Physician's name _____ Phone _____

Do you have any known allergies? Yes No

List allergies: Penicillin Anesthetics Latex Metals Others: _____

Do you take contraceptives? Yes No

Are you pregnant? Yes No

Have you tested positive for hepatitis A B C? Yes No

Have you tested positive for HIV or AIDS? Yes No

Do you smoke? Yes No

Have you been treated for substance abuse (alcohol, drugs)? Yes No

Do you have any devices or implants (pace maker, heart valve, knee, hip)? Yes No

Have you been advised to premedicate before dental treatment? Yes No

Do you bleed or bruise easily? Yes No

Have you had any surgeries? Yes No

(please specify)

Do you have any other medical problems or concerns? Yes No

(please specify)

Medical History

Please indicate below if you have now or have ever had any of the following conditions.

If you need assistance, please ask a member of our staff to assist you. Thank you.

(Circle any appropriate item you have or have had in the past)

Family illness history

Diabetes
Seizures
Cancer

High blood pressure
Heart problems
Kidney disease

Social habits

Smoking
Alcohol

Recreational drugs
Smokeless tobacco

Skin

Itching
Pigmentation
Ulcerations or sores

Rash
Loss of body hair
Lupus

Extremities

Varicose veins
Swollen-painful joints
Prosthetic devices
Osteoporosis

Muscle weakness
Arthritis
Bone deformity

Eyes

Glaucoma
Blurring of vision
Cataract surgery

Drooping eyelid
Double vision

Ear, nose, throat

Earache
Frequent nosebleeds
Hearing loss
Sinusitis

Swallowing problems
Mouth breathing
Hoarseness
Tonsil infections

Respiratory

Chronic cough
Blood in sputum
Emphysema
Bronchitis

Wheezing
Tuberculosis
Asthma

Cardiac

Shortness of breath
Angina (chest pain)
Heart murmur
Heart attack
Bypass surgery
Palpitations

Mitral valve prolapse
Pacemaker
Rheumatic fever
Swollen ankles
Balloon or Stent surgery

Gastrointestinal

Abdominal pain
Hepatitis B
Liver disease
Dialysis

Hepatitis A
Hepatitis C
Ulcers
Colitis

Genito-Urinary

Blood in urine
Kidney infection
Kidney stones
Hysterectomy (female)

Difficulty in urination or pain
Prostate problems (male)
Sexually Transmitted Disease
Endometriosis(female)

Endocrine

Hyperthyroid
Hypothyroid

Diabetes
Adrenal Gland insufficiency

Hemato-Poietic

Anemia
Easy bruising
HIV infection/AIDS
Leukemia
Spleen problems

Excessive bleeding
Chronic Fatigue Syndrome
Immune system problems
Lymph enlargement

Neurological

Seizures
Neuralgia, Neuritis
Trigeminal Neuralgia
Parkinson's

Epilepsy
Vertigo
Bells Palsy

Psychiatric/Emotional

Depression
Insomnia
Herpes

Nervousness
Nervous breakdown
Antianxiety medication

Growths or Tumors

Chemotherapy
Surgery
Mastectomy
Skin cancer

Radiation therapy
Lumpectomy
Prostate surgery

Dental History

The main purpose of you looking for professional help is:

- Emergency Establish a relationship Second opinion Restorative Cosmetic

Other specific problems that need assessment: _____

Have you been under a dentist's care over the last 2 years? Yes No

What was done in the last two years?

- Radiographs Fillings Crowns Bridges Dentures

Were there any problems called to your attention? Yes No

Please identify _____

Was any work recommended? Please identify _____

Are you on favorable terms with your prior dentist? Yes No

If not, please describe why? _____

Were you happy with the quality of care at that office? Yes No

If not, please describe why: _____

Are you comfortable with our contacting your last dentist for records? Yes No

Previous dentist: Name _____ Address _____ Phone _____

Have you participated in a regular hygiene recall program? Yes No

What was the prescribed recall for your cleanings? 6mo. 4mo. 3mo. 2mo. Monthly

Have you had any orthodontic treatment? Yes No

What type of brush do you use? Manual Rotadent Braun Interplak Water Pick

Do you floss? Yes No Daily Weekly Never

Have you been diagnosed with periodontal (gum) disease? Yes No

Have you ever had any periodontal therapy? Medication Scaling Surgery Other

Health Related Problems

Do you consider to have any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> offensive breath | <input type="checkbox"/> receding gums | <input type="checkbox"/> grind your teeth |
| <input type="checkbox"/> bad taste in your mouth | <input type="checkbox"/> spaces that catch food | <input type="checkbox"/> clench your teeth |
| <input type="checkbox"/> bleeding gums while brushing | <input type="checkbox"/> a TMJ problem | <input type="checkbox"/> jaw joints discomfort |
| <input type="checkbox"/> loose teeth | <input type="checkbox"/> a click or pop in the joints | <input type="checkbox"/> your jaw locks open or closed |

Comfort Related Problems

Yes No

are you missing teeth (besides wisdom teeth)

do you have dental implants

can you chew comfortably

do you have teeth sensitive to: (please circle) cold sweets hot pressure

Yes No

have the missing teeth been replaced

are you happy with the replacements

can you chew hard foods

Aesthetic Related Problems

Are you happy with the appearance of your smile? Yes No

Do you like the color of your teeth? Yes No

Do you like the alignment of your teeth? Yes No

Do you have a "gummy" smile? Yes No

Are you dissatisfied with your teeth in any way? (please circle) shape color spaces
Do you have any fillings that show in your: (please circle) front teeth? back teeth?

If mercury/silver fillings need replacement, would you prefer to have a more natural, tooth-color restoration instead? Yes No

If you could change one thing about your smile, what would that be? _____