

Patient Information

Name (First) (M.I.) (Last) M F Sex / / DOB S M D W Marital Status

SSN # Email address Home Phone # Cellular # Work #

Home Address(Street) (City) (State) (Zip code)

Name of Employer Occupation If student, name of school

Business Address (Street) (City) (State) (Zip code)

Spouse's Name / / DOB Occupation

Spouse's Employer Work Phone # Cellular #

Emergency contact person Phone # Relationship to you

Whom may we thank for referring you? _____

Dental Health

Reason for your visit: _____ Last teeth cleaning: _____

What is your *primary* concern that you wish us to address first? _____

Have you ever had any problems with previous dental treatment? Yes No

If yes, please explain here: _____

Are your teeth sensitive? Yes No

Do your gums feel tender or swollen? Yes No

Do you feel you don't have fresh breath? Yes No

How often do you brush your teeth? _____ How often do you floss? _____

What type of bristle do you use? Soft Medium Hard

Do you chew on only one side of your mouth? Yes No

Do you have pain with any of the following: chewing hot liquids cold liquids sweets

Are you missing teeth? Yes No

Are you aware of grinding or clenching your teeth? Yes No

Do you often have soreness of your jaws during the day or upon waking? Yes No

Are you happy with your smile? Yes No

Would you like to have whiter teeth? Yes No

If you had a magic wand, what would you change about your smile? _____

Medical History

General health Excellent Good Fair Poor

Name of physician _____ Telephone number _____

Physician's address _____

Have you ever been hospitalized? Yes No If yes, please list reason _____

Are you allergic to any medications? Yes No If yes, please list here _____

Are you taking any medications? Yes No If yes, please list current medications below:

Do you smoke? Yes No If yes, how many cigarettes per day? _____

Females only:

Are you pregnant? Yes No If yes, when is the due date? _____

Are you taking any oral contraceptives? Yes No

Have you ever had any of the following?

Allergy (Hay Fever)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sinus or Ear Trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>	Blood Disorder (Anemia, Leukemia)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Respiratory Condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Excessive Bleeding	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Severe or Frequent Headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Abnormal High/Low Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>
Kidney Disorder or Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid Condition (Hyper/Hypo)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Skin Problem or Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Parkinson's Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Nervous Disorder, Psychiatric Care	Yes <input type="checkbox"/> No <input type="checkbox"/>	Eye Disease (Glaucoma, Cataract)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Ulcer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Retinal Eye Surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer, Tumors, Malignancies	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Disease/Condition	Yes <input type="checkbox"/> No <input type="checkbox"/>
X-ray, Radium or Cobalt Treatment	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
Herpes, Cold sores, Fever blisters	Yes <input type="checkbox"/> No <input type="checkbox"/>	Scarlet Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
AIDS or HIV exposure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Murmur	Yes <input type="checkbox"/> No <input type="checkbox"/>
Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>	Transplants	Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Artificial Implants (Pacemakers, etc.)	Yes <input type="checkbox"/> No <input type="checkbox"/>

If you have answered "yes" to any of the above, please explain here:

What are your hobbies? Special interests?

Signature _____

Date _____

If patient is less than 18 years old, parent or legal guardian must sign above.