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 _____ Soc. Sec. #_____ Date _____
Last Name *First Name* *Middle Initial*

Address _____ City _____
State _____ Zip _____ Home Phone _____ Driver's Lic. No. _____
Cell Phone _____ Email _____
Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Patient Employed by _____ Occupation _____
Business Address _____
Business Email _____ Business Phone _____
Spouse Name _____ Spouse Employer _____ Spouse Soc. Sec. # _____
Spouse Business Phone _____ Spouse Cell Phone _____
Whom may we thank for referring you? _____
Emergency Contact Name _____ Relationship _____ Home Phone _____
Business Phone _____ Cell Phone _____ Email _____
Name(s) of other dependents under this plan _____

Dental History

What would you like us to do today? _____
Are you in dental discomfort today? _____
Former Dentist _____ Address _____ Phone _____
Dentist's Email _____
Date of last dental care _____ Date of last X-rays _____
Why did you leave your last dental office? _____
Check Y for yes or N for no if you have or have not had the following:

☐Y ☐N Bad breath
☐Y ☐N Food collection between teeth
☐Y ☐N Periodontal treatment
☐Y ☐N Sensitivity to sweets
☐Y ☐N Bleeding gums
☐Y ☐N Grinding or clenching teeth
☐Y ☐N Sensitivity to cold
☐Y ☐N Sensitivity when biting
☐Y ☐N Clicking or popping jaw
☐Y ☐N Loose teeth or broken fillings
☐Y ☐N Sensitivity to hot
☐Y ☐N Sores or growths in mouth

Do you smoke or dip/chew tobacco? ☐Y ☐N
How often do you brush? _____ How often do you floss? _____
How do you feel about the appearance of your teeth? _____
Are you interested in: Cosmetic dentistry? ☐Y ☐N Teeth Whitening ☐Y ☐N
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐Y ☐N

Medical History

Physician's name _____ Address _____ Phone _____
Physician's Email _____
Date of last visit ____Have you had any serious illnesses or operations? ☐Y ☐N If yes, describe _____
Are you currently under physician care? ☐Y ☐N If yes, describe _____
Have you ever had a blood transfusion? ☐Y ☐N If yes, give approximate date(s) _____
Have you ever taken Fen-Phen/Redux? ☐Y ☐N
Women: Are you pregnant? ☐Y ☐N Nursing? ☐Y ☐N Taking birth control pills? ☐Y ☐N
Check Y for yes or N for no if you have or have not had the following:

☐Y ☐N AIDS/HIV Positive
☐Y ☐N Anaphylaxis
☐Y ☐N Anemia
☐Y ☐N Arthritis, Rheumatism
☐Y ☐N Artificial heart valves
☐Y ☐N Artificial joints, pins or screws
☐Y ☐N Asthma
☐Y ☐N Atopic (allergy prone)
☐Y ☐N Back problems
☐Y ☐N Blood disease
☐Y ☐N Cancer
☐Y ☐N Chemical dependency
☐Y ☐N Chemotherapy
☐Y ☐N Circulatory problems
☐Y ☐N Cortisone treatments
☐Y ☐N Cough, persistent
☐Y ☐N Cough up blood
☐Y ☐N Diabetes
☐Y ☐N Epilepsy
☐Y ☐N Fainting
☐Y ☐N Food allergies
☐Y ☐N Glaucoma
☐Y ☐N Headaches
☐Y ☐N Heart murmur
☐Y ☐N Heart problems
Describe _____
☐Y ☐N Hemophilia/ Abnormal bleeding
☐Y ☐N Herpes
☐Y ☐N Hepatitis A, B or C
☐Y ☐N High blood pressure
☐Y ☐N Jaw pain
☐Y ☐N Kidney disease or malfunction
☐Y ☐N Liver disease
☐Y ☐N Material allergies (latex, wool, metal, chemicals)
☐Y ☐N Mitral valve prolapse
☐Y ☐N Nervous problems
☐Y ☐N Pacemaker/Heart surgery
☐Y ☐N Psychiatric care
☐Y ☐N Rapid weight gain or loss
☐Y ☐N Radiation treatment
☐Y ☐N Respiratory disease
☐Y ☐N Rheumatic fever
☐Y ☐N Scarlet fever
☐Y ☐N Shingles
☐Y ☐N Shortness of breath
☐Y ☐N Skin rash
☐Y ☐N Spina Bifida
☐Y ☐N Stroke
☐Y ☐N Surgical implant
☐Y ☐N Swelling of feet or ankles
☐Y ☐N Thyroid disease or malfunction
☐Y ☐N Tobacco habit
☐Y ☐N Tonsillitis
☐Y ☐N Tuberculosis
☐Y ☐N Ulcer/Colitis
☐Y ☐N Venereal disease

Drug Allergies:
☐Y ☐N Local Anesthetics
☐Y ☐N Penicillin or other antibiotics
☐Y ☐N Sulfa drugs
☐Y ☐N Barbituates, sedatives or sleeping pills
☐Y ☐N Aspirin
☐Y ☐N Iodine
☐Y ☐N Codeine or other narcotics

List medications you are currently taking, if any: _____

Medical History Updates:
I have read my medical history and confirm that it adequately states past and present conditions.

Date _____ Initials _____ Date _____ Initials _____ Date _____ Initials _____
Date _____ Initials _____ Date _____ Initials _____ Date _____ Initials _____
Date _____ Initials _____ Date _____ Initials _____ Date _____ Initials _____