

Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

**PATIENT INFORMATION** *Answers to all Questions are for Office Use and Strictly Confidential*

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Sex: M F Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ SS Number \_\_\_\_\_ Marital Status: S M W D

Email Address \_\_\_\_\_ Can We Contact You With This Address: Yes No

Occupation \_\_\_\_\_ Employed By \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Previous General Dentist (Name, Address & Phone Number) \_\_\_\_\_

How Did You Hear About Our Office  Friends / Co-Worker  Family  Website / Internet  Phone Book  Location  Other \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relation To You \_\_\_\_\_ Phone \_\_\_\_\_

**SPOUSE'S INFORMATION**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Sex: M F Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ SS Number \_\_\_\_\_

Occupation \_\_\_\_\_ Employed By \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Dental Insurance Company** \_\_\_\_\_ Address \_\_\_\_\_

Insured's Name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Insurance ID Number \_\_\_\_\_ Subscriber \_\_\_\_\_ Group Number \_\_\_\_\_

**Secondary Dental Insurance Company** \_\_\_\_\_ Address \_\_\_\_\_

Insured's Name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Insurance ID Number \_\_\_\_\_ Subscriber \_\_\_\_\_ Group Number \_\_\_\_\_

**MEDICAL HISTORY**

1. Are You Under A Physicians Care Now? Yes No If Yes, Explain \_\_\_\_\_
2. Have You Ever Been Hospitalized or Had A Major Operation? Yes No If Yes, Explain \_\_\_\_\_
3. Have You Ever Had A Serious Head or Neck Injury? Yes No If Yes, Explain \_\_\_\_\_
4. Are You Taking Any Medications, Drugs or Supplements? Yes No If Yes, List \_\_\_\_\_
5. Do You Take, or Have You Taken, Phen-fen or Redux? Yes No If Yes, Explain \_\_\_\_\_
6. Have You Ever Taken Any Medication Containing Bisphosphonates? Yes No If Yes, List \_\_\_\_\_
7. Are You On A Special Diet? Yes No If Yes, Explain \_\_\_\_\_
8. Do You Use Tobacco? Yes No If Yes, Explain \_\_\_\_\_
9. Do You Use Controlled Substances? Yes No If Yes, Explain \_\_\_\_\_

10. Are You Allergic To Any Of The Following?

- Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Sulfa Drugs  Local Anesthetics

Other If Other Please List: \_\_\_\_\_

MEDICAL HISTORY (Continued From Previous Page)

If You Are A Woman  Are You Pregnant or Trying To Get Pregnant  Are You Nursing  Are You Taking Oral Contraceptives

MARK AN X IN THE BOX IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING

- AIDS / HIV Positive, Alzheimer's Disease, Anaphylaxis, Anemia, Angina, Arthritis / Gout, Artificial Heart Valve, Artificial Joint, Asthma, Blood Disease, Blood Transfusion, Breathing Problems, Bruise Easily, Cancer, Chemotherapy, Chest Pains, Cold Sores / Fever Blisters, Congenital Heart Disorder, Convulsions, Cortisone Medicine, Diabetes, Drug Addiction, Easily Winded, Emphysema, Epilepsy or Seizures, Excessive Bleeding, Excessive Thirst, Fainting Spells / Dizziness, Frequent Cough, Frequent Diarrhea, Frequent Headaches, Genital Herpes, Glaucoma, Hay Fever, Heart Attack / Failure, Heart Murmur, Heart Pacemaker, Heart Trouble / Disease, Hemophilia, Hepatitis A, Hepatitis B or C, Herpes, High Blood Pressure, High Cholesterol, Hives or Rash, Hypoglycemia, Irregular Heartbeat, Kidney Problems, Leukemia, Liver Disease, Low Blood Pressure, Lung Disease, Mitral Valve Prolapse, Osteoporosis, Pain In Jaw Joints, Parathyroid Disease, Psychiatric Care, Radiation Treatment, Recent Weight Loss, Renal Dialysis, Rheumatic Fever, Rheumatism, Scarlet Fever, Shingles, Sickle Cell Disease, Sinus Trouble, Snoring / Sleep Apnea, Spina Bifida, Stomach / Intestinal Disease, Stroke, Swelling of Limbs, Thyroid Disease, Tonsillitis, Tuberculosis, Tumors or Growths, Ulcers, Venereal Disease, Yellow Jaundice

Have You Ever Had A Serious Illness Not Listed? Yes No If Yes, List \_\_\_\_\_

Do You Currently Use A CPAP Machine? Yes No How Often \_\_\_\_\_

DENTAL HISTORY

- 1. Do You Have A Specific Dental Problem? Yes No If Yes, Explain \_\_\_\_\_
2. Do You Have Dental Examinations On A Routine Basis? Yes No How Often \_\_\_\_\_
3. Would You Describe Your Present Dental Health As Good? Yes No Comments \_\_\_\_\_
4. Do You Feel Nervous About Having Dental Treatment? Yes No If Yes, Explain \_\_\_\_\_
5. Have You Ever Had A Bad Experience In A Dental Office? Yes No If Yes, Explain \_\_\_\_\_
6. Do You Want To Keep Your Remaining Teeth? Yes No If No, Explain \_\_\_\_\_
7. Do You Like Your Smile? Yes No If No, Explain \_\_\_\_\_
8. Have You Had A Reaction To Dental Anesthetic? Yes No If Yes, Explain \_\_\_\_\_
9. Do You Need To Be Pre-Medicated For Dental Treatment? Yes No If Yes, Explain \_\_\_\_\_
10. Is There Anything You Would Like To Bring To Our Attention? Yes No If Yes, Explain \_\_\_\_\_
11. Do You Wish To Talk To The Doctor Privately? Yes No
12. How Often Do You Brush? \_\_\_\_\_ Floss? \_\_\_\_\_ Use Mouthwash? \_\_\_\_\_
13. What Has Been Used For Comfort In Previous Dental Treatment?  Local Anesthetic  N2O Gas  Neither

MARK AN X IN THE BOX IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING

- Active Decay, Bleeding Gums, Gum Disease, Orthodontic Treatment, Tooth Straightening, Root Canal Treatment, Dental Implants, Removable Dental Appliances, Dentures, Hot / Cold Tooth Sensitivity, Sensitive To Sweets, Sensitive When Chewing, Bruxing or Grinding Teeth, Clicking or Popping In Jaw, Discomfort In Jaw Joint (TMJ), Food Wedging Between Teeth

Have You Ever Had Any Other Dental Procedures Not Listed? Yes No If Yes, Explain \_\_\_\_\_

Please List Any Questions, Comments or Additional Information Which May Assist Us In Providing For Your Care \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X \_\_\_\_\_ Date \_\_\_\_\_
Patient Signature (Parent or Guardian)