



Today's Date: _____

First name: _____ **MI:** _____ **Last name:** _____ **Nickname:** _____

Address: _____ **City:** _____ **ST:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **E-mail Address:** _____

Date of Birth: _____ **Social Security #** _____ **Drivers License #** _____

Are you a new patient? _____ **Referred by:** _____

Employer: _____ **Occupation:** _____

Work Address: _____ **City:** _____ **ST:** _____ **Zip:** _____

Work Phone: _____ **Extension:** _____

Party Responsible for Account: _____

Spouse or Parents Name: _____

Names of Children: _____ **Age:** _____, _____ **Age:** _____, _____ **Age:** _____

Address: (if Different) _____

Phone: _____ **Date of Birth:** _____ **Social Security #** _____

Spouse's Employer: _____ **Occupation:** _____

Spouse's Work Address: _____ **City:** _____ **ST:** _____ **Zip:** _____

Spouse's Work Phone: _____ **Extension:** _____

Person to Contact for Emergency: _____

Address: _____ **City:** _____ **ST:** _____ **Zip:** _____

Phone: _____

Closest Relative Not Living With You: _____

Address: _____ **City:** _____ **ST:** _____ **Zip:** _____

Phone: _____

Insurance Company (1): _____ **Group #** _____

Subscriber Name: _____ **Date of Birth:** _____ **Social Security #** _____

Address of Insurance: _____ **Phone#** _____

Insurance Company (2): _____ **Group #** _____

Subscriber Name: _____ **Date of Birth:** _____ **Social Security #** _____

Address of Insurance: _____ **Phone#** _____

Patient Name: _____

Date _____

Physician's Name: _____

Physician's Address: _____

Physician's Phone # _____

What is your present dental complaint: _____

DENTAL HISTORY

	YES	NO		YES	NO
Do you fear dental treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	When was your last dental cleaning _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been treated for periodontal disease (pyorrhea).....	<input type="checkbox"/>	<input type="checkbox"/>	When were your last full mouth x-rays taken _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had trench mouth.....	<input type="checkbox"/>	<input type="checkbox"/>	Are any of your teeth sensitive to biting pressure _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed.....	<input type="checkbox"/>	<input type="checkbox"/>	Are your teeth sensitive to Hot _____ Cold _____ Sweet _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty chewing your food.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any "gum boils" or gum swelling _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you grind or clench your teeth.....	<input type="checkbox"/>	<input type="checkbox"/>	Are you satisfied with the appearance of your teeth _____	<input type="checkbox"/>	<input type="checkbox"/>
Are spaces developing between your teeth.....	<input type="checkbox"/>	<input type="checkbox"/>	If not, why not _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed your bite changing.....	<input type="checkbox"/>	<input type="checkbox"/>	How would you rate your past dental care Good ___ Fair ___ Poor ___	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain in or near your ear.....	<input type="checkbox"/>	<input type="checkbox"/>	Please note any items you use in mouth care and the frequency of their use:	<input type="checkbox"/>	<input type="checkbox"/>
Do you get stress headache.....	<input type="checkbox"/>	<input type="checkbox"/>	Hand Toothbrush _____ Tooth Picks _____ Rubber Tip _____	<input type="checkbox"/>	<input type="checkbox"/>
Would you be interested in fresher breath.....	<input type="checkbox"/>	<input type="checkbox"/>	Dental Floss _____ Stimulents _____ Electric Toothbrush _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have sores in your mouth.....	<input type="checkbox"/>	<input type="checkbox"/>	Water Spray Device _____ Gum Stimulator _____ Proxabrush _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you frequently breathe through your mouth.....	<input type="checkbox"/>	<input type="checkbox"/>	Toothpaste Type _____ Mouth washes _____ Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic treatment to straighten your teeth.....	<input type="checkbox"/>	<input type="checkbox"/>			

MEDICAL HISTORY

Have You Ever Had:

	YES	NO		YES	NO
Hepatitis, Jaundice, or Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy, Convulsions, or Fainting Spells.....	<input type="checkbox"/>	<input type="checkbox"/>	Anticoagulents (Blood Thinners).....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Breakdown.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Positive test for HIV/AIDS Virus.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble or Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	Controlled Substance Use.....	<input type="checkbox"/>	<input type="checkbox"/>
High or Low Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism.....	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath.....	<input type="checkbox"/>	<input type="checkbox"/>	Any Serious Illness Not Listed.....	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains.....	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:		
Swelling in Ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	Presently under a physicians care.....	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	Taking any medications now.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease or Infection.....	<input type="checkbox"/>	<input type="checkbox"/>	Or within past year.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Allergic to Dental Anesthetic.....	<input type="checkbox"/>	<input type="checkbox"/>
a. Auto Immune Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	Aware of recent weight change.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis or Rheumatism.....	<input type="checkbox"/>	<input type="checkbox"/>	Often exhausted or fatigued.....	<input type="checkbox"/>	<input type="checkbox"/>
Stomach or Duodenal Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	Subject to frequent headaches.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses.....	<input type="checkbox"/>	<input type="checkbox"/>	A nervous person.....	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Taking nerve or sleeping medication.....	<input type="checkbox"/>	<input type="checkbox"/>
Medical Radiation Treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	Often unhappy or depressed.....	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	Taking antidepressant medication.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you bruise easily.....	<input type="checkbox"/>	<input type="checkbox"/>
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	If you smoke, how much _____		
Drug Reaction to _____	<input type="checkbox"/>	<input type="checkbox"/>	If FEMALE, are you now (please check if yes)		
Allergic to _____	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant <input type="checkbox"/> Taking anti-pregnancy drug <input type="checkbox"/>		
Venereal disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Presently in menopause <input type="checkbox"/> Post-menopause <input type="checkbox"/>		
Surgery.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you have problems with your menstrual cycle.....	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature: _____ Reviewed by: _____ Date: _____

Comments:

