Patient information

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, please don't hesitate to ask.

Patient name_____Today's date_____

Date of birth_____Age_____ Gender_____

Driver's license number_____ State_____
Home address_____
_____
Phone_____ Cell Phone_____ Email address_____
Billing address *(if different from above)* _____
_____

Employer/occupation_____Business phone_____
Spouse's name_____Spouse's phone_____
Emergency contact and phone *(other than spouse)* _____

Primary dental insurance_____ Group number_____
Secondary dental insurance_____Group number_____
Subscriber's name_____
Subscriber's insurance number_____ Date of birth_____ Age_____ Sex_____

Name of your medical doctor_____
Date of last visit to medical doctor_____

Name of previous dentist_____
Date of last visit to dentist_____
Referred to us by_____

Dental health history

Do you have or have you had any of the following?
(check all that apply)

- ☐ Apprehension about dental treatment
- ☐ Problems with previous dental treatment
- ☐ Gag easily
- ☐ Wear dentures
- ☐ Food catches between your teeth
- ☐ Difficulty chewing your food
- ☐ Chew on only one side of your mouth
- ☐ Avoid brushing any part of your mouth because of pain
- ☐ Gums bleed easily
- ☐ Gums bleed when flossing
- ☐ Gums feel swollen or tender
- ☐ Notice slow-healing sores in or around your mouth
- ☐ Feel twinges of pain when your teeth come into contact with:
    - ☐ Hot foods or liquids
    - ☐ Cold foods or liquids
    - ☐ Sour foods
    - ☐ Sweet foods
- ☐ Take fluoride supplements
- ☐ Feel dissatisfied with the appearance of your teeth
- ☐ Want to save your teeth?
- ☐ Want complete dental care?

    How often do you brush? _____
    How often to you floss? _____
- ☐ Your jaw makes noise so that it bothers you
    - ☐ Or others
- ☐ Clench or grind your teeth frequently
- ☐ Jaws feel tired
- ☐ Jaw gets stuck so that you can't open freely
- ☐ Pain when you chew or open wide to take a bite
- ☐ Earaches or pain in front of your ears
- ☐ Jaw symptoms or headaches upon awaking in the morning
- ☐ Jaw pain or discomfort affecting your appetite, sleep, daily routine, or other activities
- ☐ Jaw pain or discomfort that is extremely frustrating or depressing
- ☐ Take medications for pain or discomfort (pain relievers, muscle relaxants, antidepressants)
- ☐ Temporomandibular (jaw) disorder (TMD)
- ☐ Pain in the face, cheeks, jaws, joints, throat, or temples
- ☐ Unable to open your mouth as far as you want
- ☐ Aware of an uncomfortable bite
- ☐ Had a blow to the jaw (trauma)
- ☐ Habitually chew gum?
- ☐ Smoke a pipe?
- ☐ Use chewing tobacco?

Medical health history

Do you have or have you had any of the following? (check all that apply)

- ☐ Heart problems
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Blood pressure problem
- ☐ Heart murmur
- ☐ Heart valve problem
- ☐ Taking heart medication
- ☐ Rheumatic fever
- ☐ *Pacemaker*
- ☐ Artificial heart valve
- ☐ Blood problems
- ☐ Easy bruising
- ☐ Frequent nosebleed/abnormal bleeding
- ☐ Blood disease
- ☐ Anemia
- ☐ Ever require a blood transfusion?
- ☐ Allergy problems
- ☐ Hay fever
- ☐ Sinus problems
- ☐ Taking allergy medication
- ☐ Asthma
- ☐ Intestinal problems
- ☐ Ulcers
- ☐ Weight gain or loss
- ☐ Special diet
- ☐ Constipation/diarrhea
- ☐ Kidney or bladder problems
- ☐ Fainting spells, seizures or epilepsy
- ☐ Stroke(s)
- ☐ Frequent or severe headaches
- ☐ Thyroid problems
- ☐ Persistent cough or swollen glands
- ☐ Pre-medications required by physician
- ☐ Cancer/tumor
- ☐ Diabetes
- ☐ Urinate more than six times a day
- ☐ Thirsty or mouth is dry much of the time
- ☐ Family history of diabetes
- ☐ Tuberculosis or other respiratory disease
- ☐ Bone or joint problems
- ☐ Arthritis
- ☐ Back or neck pain
- ☐ Joint replacement (e.g. hip, pins, implants)
- ☐ Do you drink alcohol?
  If so, how much? _____
- ☐ Hepatitis, jaundice or liver trouble
- ☐ Herpes or other STD
- ☐ HIV positive/AIDS
- ☐ Glaucoma
- ☐ Do you wear contact lenses?
- ☐ Head injury
- ☐ Epilepsy or other neurologic disease
- ☐ History of alcohol or drug abuse

During the past 12 months, have you taken any of the following?

- ☐ Antibiotics or sulfa drugs
- ☐ Anticoagulants (e.g. Coumadin)
- ☐ High blood pressure medicine
- ☐ Tranquilizers
- ☐ Insulin, Tolbutamide or similar drug
- ☐ Aspirin
- ☐ Digitalis or drugs for heart trouble
- ☐ Nitroglycerin
- ☐ Cortisone (steroids)
- ☐ Natural remedies
- ☐ Nonprescription drug/supplements
- ☐ Other: _____

Are you allergic or have you reacted adversely to any of the following?

- ☐ Local anesthetics (Novocain)
- ☐ Penicillin or other antibiotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives or sleeping pills
- ☐ Aspirin, acetaminophen or ibuprofen
- ☐ Codeine, Demerol or other narcotics
- ☐ Metals
- ☐ Latex or rubber dam
- ☐ Other: _____
- ☐ What medications are you currently taking?
  taking? _____
  _____
  _____

Women

- ☐ Are you taking contraceptives or other hormones?
- ☐ Are you pregnant?
- ☐ If so, expected delivery date_____
- ☐ Have you reached menopause?
- ☐ If so, do you have symptoms?

_____ _____

Patient signature/legally authorized representative | Date

_____ _____

Printed name if signed on behalf of the patient | Relationship

_____ _____

Doctor signature | Date

3/16