PATIENT INFORMATION

HOW DID YOU HEAR ABOUT US? _____

PATIENT NAME _____

IF MINOR, GIVE PARENT OR GUARDIAN NAME _____

HOME ADDRESS _____

_____

BUSINESS ADDRESS _____

_____

OCCUPATION _____

EMERGENCY CONTACT & RELATIONSHIP _____

EMERG. CONTACT PHONE NO. ( ) _____

TODAY'S DATE _____

DATE OF BIRTH _____

HOME PHONE ( ) _____

BUSINESS PHONE ( ) _____

CELL OR PAGER NO. ( ) _____

DRIVER'S LIC. NO. _____

SOC. SEC. NO. _____

E-MAIL _____

INSURANCE CO. _____

INS. PHONE NO. ( ) _____

PHYSICIAN _____ PHYSICIAN PHONE ( ) _____ DATE OF LAST EXAM _____

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If Yes, please list _____	☐	☐
4. Do you use tobacco?	☐	☐
5. Do you drink alcohol?	☐	☐
6. Have you ever used drugs for recreational purposes or been in a substance rehab program?	☐	☐
7. Do you wear corrective glasses? or contact lenses?	☐	☐

8. Are you allergic to or have you had any reactions to the following

	YES	NO		YES	NO		YES	NO
Local anesthetics (eg. novocaine)	☐	☐	Barbituates	☐	☐	Aspirin	☐	☐
Penicillin or other antibiotics	☐	☐	Sedatives	☐	☐	Latex Sensitivity	☐	☐
Sulfa Drugs	☐	☐	Iodine	☐	☐	Other _____		

9. WOMEN ONLY:

	YES	NO
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

Do you have a history of the following?

	YES	NO		YES	NO		YES	NO
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Shortness of Breath	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Easily Fatigued	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replaced or Impaired	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Osteoporosis	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____		

_____

_____

_____

_____

_____

_____

SIGNATURE OF DENTIST DATE

PATIENT DENTAL HISTORY

Last Dental Visit _____

Last Teeth Cleaning by Dental Professional _____

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you have pain affecting any teeth, your gums, or other areas of your mouth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐

	YES	NO
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you had any orthodontic work?	☐	☐
13. Have you ever had prolonged bleeding following extractions?	☐	☐
14. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instruction on the care of your gums?	☐	☐
16. Have you ever had teeth whitening or other cosmetic dental procedures?	☐	☐

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X _____ _____

PATIENT, PARENT OR GUARDIAN SIGNATURE DATE