

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. () _____

PHYSICIAN _____

PHYSICIAN PHONE () _____

DATE OF LAST EXAM _____

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. () _____

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

8. Are you allergic to or have you had any reactions to the following?
- | | YES | NO | | YES | NO | | YES | NO |
|-----------------------------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|
| Local anesthetics (eg. novocaine) | <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other antibiotics | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives | <input type="checkbox"/> | <input type="checkbox"/> | Latex Sensitivity | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> | Iodine | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ | | |

9. WOMEN ONLY:
- | | YES | NO |
|---|--------------------------|--------------------------|
| a) Are you pregnant or think you may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Are you taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |

Do you have a history of the following?

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

SIGNATURE OF DENTIST _____

Last Dental Visit _____

PATIENT DENTAL HISTORY

Last Teeth Cleaning by Dental Professional _____ YES NO

- | | | |
|---|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have pain affecting any teeth, your gums, or other areas of your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever experienced any of the following problems in your jaw? | | |
| a) Clicking? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Pain (joint, ear, side of face)? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Difficulty in opening or closing? | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Difficulty in chewing? | <input type="checkbox"/> | <input type="checkbox"/> |

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

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