Date: _____ Sex: M __ F __ Date of Birth: _____ Marital Status: S __ M __ W __ D __

Patient Information

Name: _____ Social Security #: _____
Address: _____ Email address: _____
City: _____ State: ____ Zip: _____ Home Phone: _____
Who referred you? _____ Cell Phone: _____

Employer Information

Employer Name: _____ Work Phone: _____
Address: _____ Occupation: _____
City: _____ State: _____ Zip: _____

Party Responsible for account

Name: _____ Relationship to Patient: _____
Address: _____ Phone: _____
Employer's Name: _____ Business Phone: _____

Dental Insurance Information

Primary Insur. Carrier: _____ Insured party: _____
DOB: _____ SS#: _____
Policy #: _____ Group #: _____ Agreement #: _____

Secondary Insur. Carrier: _____ Insured party: _____
Policy #: _____ Group #: _____ Agreement #: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. PRESENT DENTAL PROBLEM _____
2. WHEN WAS YOUR LAST DENTAL VISIT? _____
3. WHAT WAS DONE? _____
4. ANY COMPLICATIONS WITH EXTRACTIONS? Y ☐ N ☐ EXPLAIN:

_____

5. HOW OLD IS YOUR DENTURE, PARTIAL, CROWN OR BRIDGE? _____
6. HOW CAN WE HELP YOU ACHIEVE THE RESULTS YOU ARE LOOKING FOR?

_____

7. WOULD YOU BE INTERESTED IN HEARING THE LATEST ON ORAL CANCER SCREENING? Y ☐ N ☐
8. WOULD YOU BE INTERESTED IN LEARNING ABOUT TEETH WHITENING? Y ☐ N ☐
9. IS THERE ANYTHING THAT YOU WOULD LIKE TO AVOID HAVING DONE? Y ☐ N ☐

_____

10. DO YOU HAVE ANY OTHER DENTAL CONCERNS? Y ☐ N ☐

_____

_____

HEALTH HISTORY

Family Physician: _____ Date of last exam: _____ Phone:

IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING, PLEASE CHECK "YES" OR "NO".

YES NO

- ☐ ☐ HEART PROBLEMS
- ☐ ☐ HIGH BLOOD PRESSURE
- ☐ ☐ LOW BLOOD PRESSURE
- ☐ ☐ CIRCULATORY PROBLEMS
- ☐ ☐ NERVOUS PROBLEMS
- ☐ ☐ RADIATION TREATMENTS
- ☐ ☐ EXCESSIVE BLEEDING
- ☐ ☐ ALLERGIES OR ADVERSE REACTIONS TO A DRUG, CODEINE, PENICILLIN, LOCAL ANESTHETIC, LATEX

_____

- ☐ ☐ ALCOHOLISM
- ☐ ☐ FREQUENT HEADACHES
- ☐ ☐ HEART MURMUR
- ☐ ☐ MALIGNANCIES
- ☐ ☐ ANXIETY, DEPRESSION

YES NO

- ☐ ☐ ANEMIA
- ☐ ☐ ARTHRITIS
- ☐ ☐ ASTHMA
- ☐ ☐ CONVULSIONS
- ☐ ☐ DIABETES
- ☐ ☐ EPILEPSY
- ☐ ☐ HEPATITIS

DATE:_____

IS YOUR DISEASE ACTIVE? Y_ N_

- ☐ ☐ DRUG ADDICTION
- ☐ ☐ JAUNDICE
- ☐ ☐ **DO YOU TAKE ASPIRIN DAILY OR BLOOD THINNERS?**
- ☐ ☐ RHEUMATIC FEVER
- ☐ ☐ ARTIFICIAL JOINT
- ☐ ☐ SINUS PROBLEMS

YES NO

- ☐ ☐ STROKE
- ☐ ☐ TUBERCULOSIS
- ☐ ☐ RESPIRATORY PROBLEMS
- ☐ ☐ PARKINSON'S DISEASE
- ☐ ☐ ULCER
- ☐ ☐ VENEREAL DISEASE
- ☐ ☐ DO YOU HAVE A CHRONIC DISEASE?
- ☐ ☐ HERPES
- ☐ ☐ ARE YOU PREGNANT?
- ☐ ☐ DO YOU TAKE BISPHOSPHONATES? (BONE STRENGTHENING DRUGS?)
- ☐ ☐ ARE YOU UNDER A DOCTOR'S CARE
- ☐ ☐ DO YOU SMOKE

OTHER MEDICAL PROBLEMS?

EXPLAIN : _____

_____

_____

LIST PRESENT MEDICATIONS

_____

_____

_____

YOUR SIGNATURE _____(PARENT OR GUARDIAN IF UNDER 16 YRS.)

DO NOT WRITE BELOW THIS LINE

Medical History Updates:

Date	Condition	Medications	Precautions