Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

About You

Today's Date _____

Name _____
Last First MI Mr Mrs Ms Dr

☐ Male ☐ Female I prefer to be called _____

Birthdate ____/____/____ Age _____ SS# _____

Home Address _____ Apt # _____

City State Zip

Home# _____ Pager/Mobile# _____

Work# _____ Ext.____DL#_____

Employer _____

Employer's Address _____

How Long There? _____ Occupation _____

Where & when are best times to reach you? _____

Who may we thank for referring you? _____

Other family members seen by us _____

Previous / Present Dentist _____
(Please circle)

Last Visit Date _____

Spouse Information

Name _____

Employer _____

Work # _____ Ext _____

SS# _____ DL# _____

Birthdate ____/____/____ Age _____

Dental History

Why have you come to the dentist today?

_____

_____

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Have you ever had any pain / tenderness in your jaw joint (TMJ / TMD) ? ☐ Yes ☐ No

Your current dental health is : ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

Medical History

Have you ever had any of the following diseases or medical problems?

Y N Heart Attack / Stroke
Y N Cancer / Chemotherapy
Y N Heart Murmur
Y N Rheumatic Fever
Y N HIV+ / AIDS
Y N Shingles
Y N Ulcers / Colitis
Y N Mitra Valve Prolapse
Y N Kidney Problems
Y N Artificial Bones / Joints
Y N Artificial Valves
Y N Sinus Problems
Y N Hepatitis
Y N Fever Blisters
Y N Emphysema / Glaucoma

Y N Psychiatric Problems
Y N Epilepsy / Seizures / Fainting Spells
Y N Diabetes / Tuberculosis (TB)
Y N Drug / Alcohol Problems
Y N Venereal Disease
Y N Heart Surgery / Pacemaker
Y N Hemophilia / Abnormal Bleeding
Y N Congenital Heart Defect
Y N Anemia / Radiation Treatment
Y N Asthma / Arthritis
Y N Difficulty Breathing
Y N Hospitalized for Any Reason
Y N High / Low Blood Pressure
Y N Blood Transfusion
Y N Severe / Frequent Headaches

Please list any serious medical condition(s) that you have ever had:

_____

Physician's Name _____

Phone # _____

Your current physical health is
☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician?
☐ Yes ☐ No

Please explain: _____

_____

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

_____

For Women

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you allergic to any of the following drugs?

Y N Penicillin
Y N Dental Anesthetics
Y N Tetracycline
Y N Erythromycin
Y N Latex
Y N Codeine
Y N Aspirin
Y N Other: _____

CONTINUED ON BACK OF FORM