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About You

Today's Date:_____ Birthdate:___/___/___ E-mail Address:_____

Name:_____ Social Security #:_____
Last First Mi Mr Mrs Ms Dr

Home Address:_____
Street City State Zip

Home Phone #:(_____)_____ Cell #:(_____)_____ Work Phone #:(_____)_____Ext:_____

Where & when are best times to reach you?_____ Whom may we thank for referring you?_____

Other family members seen by us:_____

Occupation:_____

Emergency Contact

His/Her Name:_____ Relation:_____ Work Phone #:(_____)_____ Cell #:(_____)_____

Medical History

Do you have a personal physician? ☐Yes ☐No

Physician's Name: _____

Address: _____

Phone #:(_____)_____ Date of last visit:_____

Your current physical health is? ☐Good ☐Fair ☐Poor

Are you under a PHYSICIANS care now? ☐Y ☐N

For what: _____

Are you currently taking and medication? ☐Y ☐N

If yes, what: _____

_____

Have you ever taken Phen-Fen, Redux or Pondimin? ☐Y ☐N
Are you taking meds for Osteoporosis? ☐Y ☐N
Do you smoke or use tobacco in any other form? ☐Y ☐N
Are you on blood thinners? ☐Y ☐N
For Women: Are you taking birth control pills? ☐Y ☐N
Are you Pregnant? ☐Unsure ☐Y ☐N
Week #:_____? Are you nursing? ☐Y ☐N

Do you or have experienced the following?

Heart Attack	☐Y ☐N	Hepatitis A (infectious)	☐Y ☐N	Asthma	☐Y ☐N
Heart Disease	☐Y ☐N	Hepatitis B (serum)	☐Y ☐N	Hay Fever	☐Y ☐N
Angina Pectoris	☐Y ☐N	Liver Disease	☐Y ☐N	Sinus Trouble	☐Y ☐N
High Blood Pressure	☐Y ☐N	Yellow Jaundice	☐Y ☐N	Allergies or Hives	☐Y ☐N
Heart Murmer	☐Y ☐N	Blood Transfusion	☐Y ☐N	Diabetes	☐Y ☐N
Rheumatic Fever	☐Y ☐N	Drug Abuse	☐Y ☐N	Thyroid Disease	☐Y ☐N
Congenital Heart Lesions	☐Y ☐N	Hemophilia	☐Y ☐N	X-Ray/Cobalt Treatment	☐Y ☐N
Scarlet Fever	☐Y ☐N	Fever Blisters	☐Y ☐N	Arthritis	☐Y ☐N
Artificial Heart Valves	☐Y ☐N	Epilepsy or Seizures	☐Y ☐N	Rheumatism	☐Y ☐N
Heart Pacemaker	☐Y ☐N	Fainting or Dizzy Spells	☐Y ☐N	Cortisone Medication	☐Y ☐N
Heart Surgery	☐Y ☐N	Nervousness	☐Y ☐N	Pain in Jaw Joints	☐Y ☐N
Artificial Bones/Joints	☐Y ☐N	Psychiatric Treatment	☐Y ☐N	Alcoholism	☐Y ☐N
Anemia	☐Y ☐N	Sickle Cell Disease	☐Y ☐N	Bleeding Problems	☐Y ☐N
Stroke	☐Y ☐N	Glaucoma	☐Y ☐N	A.I.D.S.	☐Y ☐N
Kidney Trouble	☐Y ☐N	Chemotherapy	☐Y ☐N	Bruise Easily	☐Y ☐N
Ulcers	☐Y ☐N	Venereal Disease	☐Y ☐N	Emphysema	☐Y ☐N
Cosmetic Surgery	☐Y ☐N	Tuberculosis (TB)	☐Y ☐N	Chicken Pox/Shingles	☐Y ☐N

Please list any serious medical condition(s) that you have experienced:_____

Are you taking any prescription/over the counter drugs? ☐Y ☐N If yes, please list each one:_____

_____

Are you allergic to any of the following?

Aspirin	☐Y ☐N	Erythromycin	☐Y ☐N	Sedatives	☐Y ☐N
Barbiturates	☐Y ☐N	Jewelry/Metals	☐Y ☐N	Sulfa Drugs	☐Y ☐N
Codeine	☐Y ☐N	Latex	☐Y ☐N	Tetracycline	☐Y ☐N
Dental Anesthetics	☐Y ☐N	Penicillin	☐Y ☐N	Other _____	Y N

Dental History

Why have you come to the dentist today? _____

How long has it been since you have seen a dentist? _____

Are you currently in pain? ☐Y ☐N

Do you require antibiotics before dental treatment? ☐Y ☐N

Are you aware of being ALLERGIC TO or reacting adversely to any medications or subtances in the dental office? ☐Y ☐N

If YES please list? _____

Periodontics

Office Use Only

H

M

L

Types of bristles on your toothbrush? Hard☐ Medium☐ Soft☐

Have you had any PERIODONTAL (GUM) treatment? ☐Y ☐N

Do your gums BLEED, or feel TENDER, or IRRITATED? ☐Y ☐N

Are your teeth sensitive to cold? ☐Y ☐N

Do you have LOOSE, TIPPED, or SHIFTING teeth? ☐Y ☐N

Do you have dry mouth? ☐Y ☐N

Do you have bad breath? ☐Y ☐N

Do you have spaces where food gets trapped? ☐Y ☐N

Lower☐ Upper☐

Right☐ Left☐

Caries

Office Use Only

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M

L

Do you have any dark, silver fillings? ☐Y ☐N

Do you drink soda or energy drinks? ☐Y ☐N

Do you have acid reflux? ☐Y ☐N

Forces

Office Use Only

H

M

L

Are you aware of GRINDING or CLENCHING your teeth? ☐Y ☐N

Do you have HEADACHES, EARACHES, or NECK PAINS? ☐Y ☐N

Do you have problems with teeth/fillings BREAKING? ☐Y ☐N

Do you have pain/discomfort in your jaw joint? ☐Y ☐N

Do you snore or have sleap apnea? ☐Y ☐N

Do you CHEW/EAT on a regular basis: Acidic Food/Drink☐ Ice☐ Gum☐ Nut☐ Finger Nails☐

Esthetics

Office Use Only

H

M

L

Do you want straighter teeth? ☐Y ☐N

Do you want whiter teeth? ☐Y ☐N

Have you worn BRACES on your teeth? (ORTHODONTICS) ☐Y ☐N

Is it difficult to floss your teeth because of crooked or crowded teeth? ☐Y ☐N

Authorization

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. ***I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.***

- I understand that there can be charges for broken appointments and cancelled appointments without 48 hours in advanced notice.
- I Authorize the doctorto take x-rays, study models, photographs, or any otherdiagnostic aids deemed appropiate and necessaryby the doctor to make a thorough diagnostic and provide treatment.
- I authorize the doctor to use them in presentations, lectures and publications.

_____ _____

Signature Date