## PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form.

Home address:   City:   State:   Zip:	Patient name:			Date of birth:	Sex	c: A(	ge:
Employer Name & Phone#:   Employer Occupation:   Bus. Phone:	Home address:			City:	State:	Zip:	
SS#:	Billing address (if different):			City:	State:	Zip:	
Spouse's Name & Phone#:	Home phone:	Cell:		E	mail:		
Primary dental insurance:	SS#:	Employer/Occ	cupation:		Bus. Phone	e:	
Employee Name: D.O.B.: Group #: D.O.B.:    Employee Name: D.O.B.:    Name of your medical doctor: Date of last visit to medical doctor:    Name of previous dentist: Date of last visit to dentist:    Referred to us by:    DENTAL HEALTH HISTORY    YES NO   YES NO    Are you apprehensive about dental treatment?   Deyou apprehensive about dental treatment?   Deyou gag easily?    Do you gag easily?   Do you gag easily?   Do you gag easily?    Do you have ar dentures?   Do you dave ar dentures?   Do you dave defloutly in chewing your food?   Do you have artificulty in chewing your food?   Do you avoid brushing any part of your mouth   Do you have any jaw symptoms or headaches upon awaking in the morning?   Do you gums bleed vhen you floss?   Do you have any jaw symptoms or headaches upon awaking in the morning?   Do you fred twinges of pain when your teeth come in contact with:   Hot foods or fiquids?   Do you have a temporomandibular (jaw) disorder (TMD)?   Codi foods or liquids?   Do you have fleativeness, jaws, joints, throat, or tempelse?   Do you have gain in the face, cheeks, jaws, joints, throat, or tempelse?   Do you have gain in the face, cheeks, jaws, joints, throat, or tempelse?   Do you have gain in the face, cheeks, jaws, joints, throat, or tempelse?   Do you have gain in the face, cheeks, jaws, joints, throat, or tempelse?   Do you have gain in the face, cheeks, jaws, joints, throat, or tempelse?   Do you have gain in the face, cheeks, jaws, joints, throat, or tempelse?   Do you have gain in the face, cheeks, jaws, joints, throat, or tempelse?   Do you have gain in the face, cheeks, jaws, joints, throat, or tempelse?   Do you have gain in the face, cheeks, jaws, joints, throat, or tempelse?   Do you have gain in the face, cheeks, jaws, joints, throat, or tempelse?   Do you have gain in the face, cheeks, jaws, joints, throat, or tempelse?   Do you have gain the gas treatment?   Do you have gain the gas treatment?   Do you have gain the temporomandibular (jaw) disorder (TMD)?   Do you have gain in the fac	Spouse's Name & Phone#:			Emergency phone #	# (Other than spouse):		
Secondary dental insurance:	Primary dental insurance:			ID #:		Group #:	
Employee Name: D.O.B.:  Name of your medical doctor: Date of last visit to medical doctor:  Name of previous dentist: Date of last visit to medical doctor:  Referred to us by:    DENTAL HEALTH HISTORY	Employee Name:				D.O.B.: _		
Name of your medical doctor:    Date of last visit to medical doctor:	Secondary dental insurance:			ID #:		Group #:	
Referred to us by:    DENTAL HEALTH HISTORY   YES   NO   NO	Employee Name:				D.O.B.: _		
DENTAL HEALTH HISTORY  YES NO  Are you apprehensive about dental treatment?   How often do you brush?   How often do you brush?   How often do you brush?   How often do you floss?  Do you gag easily?   Does your jaw make noise so that it bothers you or others?   Doe you clench or grind your jaws frequently?   Does your jaw frequently?   Does your jaw sever feel tired?   Does your jaws ever feel tired?   Does your jaw get stuck so that you cant open freely?   Does your jaw get stuck so that you cant open freely?   Does your jaws ever feel tired?   Does your jaw get stuck so that you cant open freely?   Does your jaw get stuck so that you cant open freely?   Does your jaw get stuck so that you cant open freely?   Does it hurt when you chew or open wide to take a bite?   Does your gums bleed easily?   Does it hurt when you chew or open wide to take a bite?   Does your gums bleed when you floss?   Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?:   Does jaw pain or discomfort extremely Frustrating or depressing?   Does jaw pain or discomfort extremely Frustrating or depressing?   Does you fave a temporomandibular (jaw) disorder (TMD)?   Does have a temporomandibular (jaw) disorder (TMD)?   Does have pain in the face, cheeks, jaws, joints, throat, or temples?   Are you unable to open your mouth as far as you want?   Dees you prefer to save your teeth?   Dees you have a pain you have a pain in the face, cheeks, jaws, joints, throat, or temples?   Dees you have pain in the face, cheeks, jaws, joints, throat, or temples?   Dees you have pain in the face, cheeks, jaws, joints, throat, or temples?   Dees you have part of your teeth?   Dees you have part of you want of an unconfortable bite?   Dees you have part of your teeth?   Dees you have part of your mouth as far as you want?   Dees you have part of your mouth as far as you want?   Dees you have part of your mouth as far as you want?   Dees you have part of your mouth as far as you want?   Dees you have part of your have a	Name of your medical doctor:			Date of last visit to	medical doctor:		
DENTAL HEALTH HISTORY  YES NO  Are you apprehensive about dental treatment?     How often do you brush?   How often do you floss?   Doy ug age asily?   Does your jaw make noise so that it bothers you or others?   Do you wear dentures?   Do you wear dentures?   Do you say of the description of discomfort affect your appetite, sour sour sour sour sour sour sour sour	Name of previous dentist:			_ Date of last visit to	dentist:		
How often do you floss?  Do you gag easily?  Do you war dentures?  Do you have a dentures?  Do you have difficulty in chewing your food?  Do you chew on only one side of your mouth?  Do you avoid brushing any part of your mouth  because of pain?  Do your gums bleed easily?  Do your gums bleed when you floss?  Do your gums feel swollen or tender?  Do your gums feel swollen or tender?  Do your gums feel swollen or tender?  Do you rever noticed slow-healing sores in or about your mouth?  Do you reel twinges of pain when your teeth come in contact with:  Hot foods or liquids?  Cold foods or liquids?  Do you take fluoride supplements?  Are you use feel tired?  Does your jaws ever feel tired?  Does your jaws ever feel tired?  Does your jaws ever feel tired?  Does your jaw get stuck so that you cant open freely?  Does it hurt when you chew or open wide to take a bite?  Do you have earaches or pain in front of the ears?  Do you have any jaw symptoms or headaches  upon awaking in the morning?  Does jaw pain or discomfort affect your appetite,  sleep, daily routine, or other activities?:  Do you feel twinges of pain when your teeth come in  contact with:  Hot foods or liquids?  Cold foods or liquids?  Cold foods or liquids?  Do you have a temporomandibular (jaw) disorder  (TMD)?  Do you have pain in the face, cheeks, jaws, joints,  throat, or temples?  Are you unable to open your mouth as far as you want?  Are you are defined the papearance of your teeth?  Have you have a biviliual num chewer or nine smoker?  Are you as abilitual num chewer or nine smoker?	Referred to us by:	DEN	TAL HE			١	/ES NO
contact with:  Hot foods or liquids?  Cold foods or liquids?  Sours?  Sweets?  Do you have a temporomandibular (jaw) disorder  (TMD)?  Do you have pain in the face, cheeks, jaws, joints, throat, or temples?  Are you unable to open your mouth as far as you want?  Are you dissatisfied with the appearance of your teeth?  Do you prefer to save your teeth?  Have you had a blow to the jaw (trauma)?  Are you a habitual gum chewer or pipe smoker?	Do you gag easily?  Do you wear dentures?  Does food catch between your teeth?  Do you have difficulty in chewing your food?  Do you chew on only one side of your mouth?  Do you avoid brushing any part of your mouth  because of pain?  Do your gums bleed easily?  Do your gums bleed when you floss?  Do your gums feel swollen or tender?  Have you ever noticed slow-healing sores in or  about your mouth?  Are your teeth sensitive?			Does your jaw ma or others?  Do you clench or Do your jaws ever Does your jaw ger Does it hurt when Do you have eara Do you have any upon awaking Does jaw pain or o sleep, daily ro Do you find jaw pa	grind your jaws frequen feel tired? t stuck so that you cant you chew or open wide ches or pain in front of t jaw symptoms or heada g in the morning? discomfort affect your ap outine, or other activities ain or discomfort extrem depressing?	tly?[ open freely?[ to take a bite?[ the ears?[ aches[ ppetite, s?:[	
	contact with:  Hot foods or liquids?  Cold foods or liquids?  Sours?  Sweets?  Do you take fluoride supplements?  Are you dissatisfied with the appearance of your tee.  Do you prefer to save your teeth?			(pain relievers, mu Do you have a ter (TMD)?  Do you have pain throat, or tem Are you unable to Are you aware of Have you had a b	in the face, cheeks, jaw ples?open your mouth as far an uncomfortable bite? low to the jaw (trauma)?	ressants? [ disorder  vs, joints,  r as you want? [	

## MEDICAL HEALTH HISTORY Do you have, or have you had, any of the following?

	Yes	<u>No</u>			Yes	No
Heart Problems				Diabetes		
Chest pain				Urinate more than 6 times a day		
Shortness of breath				Thirsty or mouth is dry much of the time _		
Blood pressure problem	_ 🗆			Family history of diabetes	_	
Heart murmur	_ 🗆			· · · · · · · · · · · · · · · · · · ·		_
Heart valve problem				Tuberculosis or other respiratory disease	Ш	Ш
Taking heart medication				Do you drink alcohol?		
Rheumatic fever	$_{-}$			If so, how much?		
Pacemaker	$_{-}$			Do you smoke?		
Artificial heart valve	_ 🗆			If so, how much?		H
Blood Problems						
Easy bruising				Hepatitis, jaundice, or liver trouble	Ш	Ш
Frequent nosebleeds				Herpes or other STD		
Abnormal bleeding				HIV-positive/AIDS	П	
Blood disease (anemia)						_
Ever require a blood transfusion?	_ 🗆			Glaucoma		
Allergy Problems	_			Do you wear contact lenses?		
Hay fever	- □	닏		History of head injury?		
Sinus problems		$\sqcup$		Epilepsy or other neurological disease?		
Skin rashes		님				
Taking allergy medication	_	님		History of alcohol or drug abuse?		
Asthma	_ ⊔	Ш		Do you have any disease, condition, or prob	ıem not li	isted
Intestinal Problems	П			previously that you feel we should know a	about?	
Ulcers				If so, please describe:		
Weight gain or loss						
Special diet						
Constipation/Diarrhea				During the past 12 months, have you taken		
Kidney or bladder problems				any of the following?	Yes	s No
Dana an Isint Buchlama				•		
Bone or Joint Problems Arthritis	- H	H		Antibiotics or sulfa drugs	H	: H
Back or neck pain	- H	H		Anticoagulants (e.g., Coumadin)	⊢	
Joint replacement		H		High blood pressure medicine	片	: H
(e,g, total hip, pins, or implants)	- Ш			Tranquilizers	⊢	. H
(e,g, total rlip, pills, of implants)				Insulin, Orinase, or similar drug	H	! !!
Fainting Spells, Seizures, or Epilepsy				Aspirin	닏	: H
Stroke(s)				Digitalis or frugs for heart trouble		: H
		$\overline{}$		Nitroglycerin	닏	
Frequent or severe headaches	- 닏			Cortisone (steroids)	H	!
Thyroid problems	_ ⊔	Ш		Natural remedies		<u> </u>
Persistent cough or swollen glands				Nonprescription drug/supplements	ш	
Premedications required by physician	П			Other		
Cancer/Tumor		$\overline{}$				
Cancer Turnor	_ ⊔	Ш		Women	Var	s No
e you allergic, or have you reacted advers	e o by			Are you taking contraceptives or	Yes	, NO
to any of the following?	ociy,	Yes	No	other hormones?		
Local anesthetics ("Novocaine")				Are you pregnant?		
Penicillin or other antibiotics		Ħ	H	if so, expected delivery date:		
Sulfa drugs		Ħ	H	Are you nursing:		
Barbiturates, sedatives, or sleeping pills		Ħ	H			
		Ħ	H	Have you reached menopause?	Ц	' Ц
Aspirin, Acetaminophen, or Ibuprofen		H	H	if so, do you have any symptoms?		
Codeine, Demerol, or other narcotics		H	H			
Reaction to metals		H	H			
Latex or rubber dam		ш	Ш	Notes:		
Other				Notes:		
otes:						
				Patient/Paarent Signature:		
	Date: _			Dentist Initial:		