Patient Information

Todays Date___/___/____ Patient's Birthdate___/___/____ Patient's Gender - M / F

Name_____
First MI Last

Address_____City_____ State _____Zip _____

E-Mail_____Cell Phone(_____)_____-_____Home Phone(_____)_____-_____

Patient is (Check Appropriate Box): ❑ a Minor; ❑ Single; ❑ Married; ❑ Divorced; ❑ Widowed; ❑ Separated

If a Minor - Father's Name_____ Birthdate___/___/____ S.S.# _____-____-_____

E-Mail_____Cell Phone(_____)_____-_____Home Phone(_____)_____-_____

Mother's Name_____ Birthdate___/___/____ S.S.# _____+-____-_____

E-Mail_____Cell Phone(_____)_____-_____Home Phone(_____)_____-_____

Dental History

What is the reason for this visit?_____

When was your last dental visit?_____ What was done then?_____

Previous Dentist (Name & Location)_____

Has a complete series of dental films (X-rays) been taken? (when/where)_____

How often do you brush your teeth?_____ How often do you floss your teeth?_____

Yes	No		Yes	No	
❑	❑	Is your Drinking Water Fluoridated?	❑	❑	Does food tend to become caught between your teeth?
❑	❑	Do your gums bleed while brushing or flossing?	❑	❑	Have you ever had periodontal (gum/bone) treatment?
❑	❑	Are your teeth sensitive to hot or cold liquids/foods?	❑	❑	Have you ever had a difficult extraction in the past?
❑	❑	Are your teeth sensitive to sweet/sour liquids/foods?	❑	❑	Have you ever had prolonged bleeding after an extraction?
❑	❑	Do you feel pain in any of your teeth?	❑	❑	Do you wear dentures or partial dentures? If Yes, Date of Placement_____
❑	❑	Do you have sores or lumps in or near your mouth?			
❑	❑	Have you had any head, neck or jaw injuries?			**Have you ever experienced any of the following problems in your jaw?**
❑	❑	Do you have frequent headaches?			
❑	❑	Do you clench or grind your teeth?			Clicking or Popping ---------- Yes ❑ No ❑
❑	❑	Have you ever worn a bite plate or other appliance?			Pain in the joint, ear or side of your face - Yes ❑ No ❑
❑	❑	Do you bite your lips or cheeks frequently?			Difficulty opening or closing ---------- Yes ❑ No ❑
❑	❑	Have you noticed any loosening of your teeth?			Difficulty chewing ---------- Yes ❑ No ❑

If you could change anything about your smile, What would you change?_____

_____

Medical History

WOMEN ONLY: Are you Pregnant? Or Think you may be Pregnant? ❑Yes ❑No
Are you Nursing? ❑Yes ❑No Are you taking Birth Control Pills? ❑Yes ❑No

Yes No **Are you Allergic to or have you had a reaction to any of the following: (circle all conditions that apply)**

❑ ❑ Food, Latex, Pollen, Hayfever, Seasonal Allergies, Animal(s), Nickel or other Metals
❑ ❑ Medicines, such as, Local Anesthetic, Penicillin, Amoxicillin, Sulfa Drugs, Cephalosporins, Keflex, Iodine
❑ ❑ Other Substance(s)_____ For Yes responses (above), Please describe the reaction(s) that occurred:

_____

Do you have or have you ever had any of the following: (check all conditions that apply)

❑ Asthma	❑ Learning Disorder	❑ Cancer	❑ Liver Disease	❑ High Blood Pressure
❑ Pneumonia	❑ Visual Impairment	❑ Chemotherapy	❑ Hepatitis	❑ Rheumatic Fever
❑ Headaches	❑ Hearing Impairment	❑ Hemophilia	❑ Kidney Disease	❑ Heart Damage
❑ Dizziness	❑ ADD or ADHD	❑ Sickle-Cell Anemia	❑ Crohn's Disease	❑Congenital Heart Defect
❑ Seizure Disorder	❑ Mental Health Care	❑ Anemia	❑ Malnutrition	❑ Tuberculosis (TB)
❑ Stroke	❑ Nervousness	❑ Blood Transfusion	❑ Eating Disorder	❑ Autoimmune Disorder
❑ Cerebral Palsy	❑ Traumatic Brain Injury	❑ Abnormal Bleeding/Bruising	❑ Immunosuppression (from Drugs / Radiation)	
❑ Arthritis	❑ Gastric Tube (G-Tube)	❑ Gastrointestinal Disease	❑ GERD (Gastroesophageal Reflux Disease)	
❑ Diabetes___Type I (Insulin dependent)/___Type II (Non-insulin dependent)			❑ Thyroid Disorder	❑ Genitourinary Disease

❑ Other Hormonal Disorders - Please specify: _____
❑ Genetic Disorder(s) / Condition(s) - Please specify: _____
❑ Other Disease(s), Condition(s) or Problem NOT listed above…_____

I certify that I have read and understand the above information. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his or her staff, responsible for any action they take or do not take because of errors or omissions that I have made in the completion of this form. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health or (in the case of a minor child) my child's health. It is my responsibility to inform the dental office of any changes in the current medical status as they occur.

I authorize the dental staff to perform the necessary dental services that may be needed for myself or my child (in the case of a minor child).

_____ _____
Signature of the patient (or the parent / guardian, if the patient is a minor) Date

_____ _____
Signature of the dentist Date

NOTES: