

**Patient Information**

Name \_\_\_\_\_ Today's Date \_\_\_/\_\_\_/\_\_\_ Patient's Birthdate \_\_\_/\_\_\_/\_\_\_ Patient's Gender - M / F

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,

Do you have sores or lumps in or near your mouth? \_\_\_\_\_ Date of Placement \_\_\_\_\_

Have you had any head, neck or jaw injuries? \_\_\_\_\_

Do you have frequent headaches? \_\_\_\_\_

Do you clench or grind your teeth? \_\_\_\_\_

Have you ever worn a bite plate or other appliance? \_\_\_\_\_

Do you bite your lips or cheeks frequently? \_\_\_\_\_

Have you noticed any loosening of your teeth? \_\_\_\_\_

**Have you ever experienced any of the following problems in your jaw?**

Clicking or Popping ----- Yes  No

Pain in the joint, ear or side of your face - Yes  No

Difficulty opening or closing ----- Yes  No

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: