Patient Information

Whom may we thank for referring you to our office? Name or Source _____

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Physical Address: _____
Street Apartment #

_____
City State Zip Code

e-mail address: _____ Occupation: _____
To be used to contact you about recalls, Insurance, appointments, and other information from our office only.

Name of nearest relative not living with you _____ Phone _____

Dental History

Reason for today's visit: _____ Date of last dental care: _____

Have your ever had any of the following? Please check those that apply:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Food Collection between teeth
- ☐ Periodontal treatment
- ☐ Sores or growths in your mouth
- ☐ Sensitivity to sweets
- ☐ Sensitivity to biting
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot

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

Health History

Have your ever had any of the following? Please check those that apply:

- ☐ Alcohol/Drug Addiction
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Codeine Allergy
- ☐ Diabetes
- ☐ Dizziness or Fainting
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A B C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Pos/AIDS
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Penicillin Allergy
- ☐ **Pregnant**
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers

OTHER:

- ☐ _____
- ☐ _____

- **Are you currently taking or occasionally using any over the counter drugs, street drugs, prescription drugs, or other medications?** ☐ Yes ☐ No If yes, please list: _____

_____

- Are you currently using any tobacco products (smokeless included)? ☐ Yes ☐ No
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I have any change in my health, I will inform the doctor at my next appointment.

_____ Date: _____
Signature of patient, parent or guardian