PATIENT INFORMATION

Please Print

Name ____ Date __________________

Phone numbers: Home ______________ Work _______________ Cell _______________

Home Address ____

City, State, Zip _____________________________ E-Mail __________________________

Social Security#_________________ Birth Date____________ Martial Status: Single Married

Spouse Name__________________ How did you hear of our office? _____________________

EMPLOYER INFORMATION

Employer _______________________________________ Occupation ___________________

Business address, city, state, zip ____

Dental insurance co. & address ____

DENTAL HEALTH HISTORY

The reason for your visit today:

Are you happy with the look, shape and whiteness of your teeth? yes no

Please elaborate____

Have you ever had a serious problem with a previous dental visit? If so, please explain ______

_____________________________________ The date of your last dental visit ____________

Are your teeth sensitive to hot, cold, pressure or sweets? yes no

When chewing, do you experience pain in any part of the mouth, jaw or teeth? yes no

Does food catch between your teeth? ________ Where?________________________________

Do your gums bleed while chewing, brushing or at anytime? yes no

Do you chew on both sides of your mouth? yes no

Do your jaws feel tired, out of joint or click when you open your mouth? yes no

Are you aware of a bad taste or odor in your mouth? yes no

Do your gums feel tender or swollen? yes no

Do you clench or grind your teeth? yes no Have you ever worn braces? yes no

Do you experience:

- Cracking in the corners of your mouth yes no Burning of the tongue yes no
- Frequent fever blisters on the lips or mouth yes no

MEDICAL HISTORY

Are you under a physician's care? ________ Whom?__________________________________

Physician's phone number______________________________ Have you ever had to take pre-medication before dental procedures? ________ For what? ____

Are you aware of any current medical problems? yes no What? ______________________________

____ Last physical date __________________

Have you ever had any of the following?

Rheumatic fever	yes	no	Heart murmur	yes	no
Mitral valve prolapse	yes	no	Knee, hip, joint replacement	yes	no
Are you pregnant?	yes	no			

Please list all allergies to medications ____

Are you currently taking medications? yes no For what? ____

Have you ever been treated for:

Abnormal blood pressure	yes	no	Heart disease or stroke	yes	no
Lung disease or tuberculosis	yes	no	Congenital heart lesions	yes	no
Kidney disease	yes	no	Ulcers	yes	no
Hepatitis	yes	no	Glaucoma	yes	no
Jaundice (liver)	yes	no	Sinus trouble	yes	no
Diabetes (blood sugar)	yes	no	Anemia	yes	no
Epilepsy	yes	no	Asthma or hay fever	yes	no
Arthritis	yes	no	Venereal disease	yes	no
HIV/AIDS	yes	no	Persistent cough or cough up blood	yes	no

Other:

Frequent backaches?	yes	no	Neck pain?	yes	no
Diarrhea?	yes	no	Vomiting?	yes	no
Fainting spells?	yes	no	Upper chest pain?	yes	no
Non-healing sores?	yes	no	Recent weight gain	yes	no
Do you have frequent headaches? Severity? ________________________________	yes	no	Do you urinate frequently or have excessive thirst?	yes	no

Do you have abnormal bleeding associated with injury or trauma? yes no

Have you had surgery or radiation treatment for growths or conditions of the mouth or other body parts? yes no

Please make additional comments concerning any recent illness, operations, medications, or your physical health in general:

This information is a true and correct representation of my medical health.

____ ______________________________

Signature Date