## PATIENT INFORMATION

Please Print

Name _____ Date _____

Phone numbers: Home _____ Work _____ Cell _____

I prefer to be confirmed via: (Please circle choice): Phone Call eMail Txt Message

Home Address _____

City, State, Zip _____ E-Mail _____

Social Security#_____ Birth Date_____ Martial Status: Single Married

Spouse Name_____ **How did you hear about us? _____**
**If you heard about us on the Internet, which website? _____**
**If you heard about us via Natural Awakenings Magazine, which mag? Choose below:**
**Tampa ___ Sarasota ___**

## EMPLOYER INFORMATION

Employer _____ Occupation _____

Business address, city, state, zip _____

**If you wish to have an Insurance Claim, please provide an Insurance Card.**

## 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 |
| High or Low blood pressure? | yes | no | Congenital heart lesions | yes | no |
| Lung disease or tuberculosis | yes | no | Ulcers | yes | no |
| Kidney disease | yes | no | Glaucoma | yes | no |
| Hepatitis A, B, C | yes | no | Sinus trouble | yes | no |
| Jaundice (liver) | yes | no | Anemia | yes | no |
| Diabetes (blood sugar) | yes | no | Asthma | yes | no |
| Epilepsy | yes | no | Venereal disease | yes | no |
| Arthritis | yes | no | Persistent cough or cough up blood | yes | no |
| HIV/AIDS | 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