

Personal Information



Patient's Last Name

First Name

Middle Initial

Preferred Name / Nickname

(Responsible Party's Name, if not the patient)

(Relationship to Patient)

Date of Birth

Patient Sex: Male Female

Home Address

City

State

ZIP

Mobile Number :

Home Number :

Work Number :

E-mail :

Who may we thank for referring you to our office?
(or please tell us how you heard of us)

Which other family members are patients at this office?

Insurance Information

Subscriber's Name (e.g. name of head of household)

Insurance Company Name

Subscriber's Date of Birth

Subscriber ID Number

Subscriber's Relationship to Patient (e.g., self / spouse)

Name of Subscriber's Employer

Group ID Number

Emergency Contact Information

Name of Emergency Contact

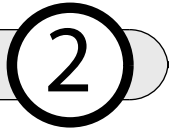
Relationship to Patient

Home Telephone Number

Work Telephone Number

Cell or Other Telephone Number

Dental History & Treatment Options



Date of Last Dental Visit: _____

Former Dentist: _____

Date of Last X-rays: _____

... in City, State: _____

Yes No Do you feel that your mouth (or jaw) functions properly?

Yes No Are you happy with the appearance of your teeth/smile?

Yes No Are all of your teeth in alignment (straight)?

Yes No Do you have any old fillings, crowns, or dental treatment(s) that you are concerned about or unhappy with?

Would you like to change anything about your teeth/smile?

Please let us know if you would like information about any of the following:

- Invisalign (clear braces)
- Porcelain veneers
- Whitening / Bleaching
- Making teeth look taller
- Closing gaps between teeth

Yes No Are you fearful of dental treatments?

If YES, rate your fear level from 1 (some fear) to 10 (incredibly fearful)

What is the trigger for your fear? (check all that apply)

- Needles
- Smells
- Sounds
- Fear of pain

Check if you have had problems with any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Periodontal (gum) treatment |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Grinding/clenching teeth | <input type="checkbox"/> Prolonged bleeding after extraction |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sensitivity to biting/chewing |
| <input type="checkbox"/> Difficult opening or closing of jaw | <input type="checkbox"/> Jaw pain or tiredness | <input type="checkbox"/> Sensitivity to cold/hot/sweets |
| <input type="checkbox"/> Difficult extractions in the past | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sores, lumps, growths in your mouth |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Swollen or tender gums |

Medical History

Date of Last Physician Visit: _____

Name of Physician: _____

... in City, State: _____ Tel. No.: _____

Yes No Have you had any serious illnesses, operations, or hospitalizations? If YES, please give dates and reason: _____

Yes No Have you ever had a blood transfusion? If YES, please give dates and reason: _____

Medical History (continued)

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Check any of the following which apply to you:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis - Type: _____ | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough -- Persistent or Bloody | <input type="checkbox"/> Herpes / Cold Sores (blisters) | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes -- Type (1 or 2): _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Arthritis -or- Rheumatism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Skin Rash / Hives |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial / Replacement Joints | <input type="checkbox"/> Fainting / Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequently Tired | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hay Fever / Seasonal Allergies | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemical / Drug Addiction | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Murmurs / Irregular Beat | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Other: _____ |

Women only:

Yes No Are you currently pregnant?
(or think that you might be?)

Yes No Are you nursing?

Tobacco user?

Yes No

What kind, how many years, how often?

Medications you are currently taking: (including over-the-counter)

Are you currently taking or have you taken any of the following?

- | | |
|---|----------------------------------|
| <input type="checkbox"/> Fen-Phen/Redux | <input type="checkbox"/> Actonel |
| <input type="checkbox"/> Boniva | <input type="checkbox"/> Fosomax |

Vitamins / Minerals / Supplements / Herbal:

Allergies:

- | | | |
|---|--|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Antibiotics (e.g. Penicillin) |
| <input type="checkbox"/> Barbiturates (e.g. sleeping pills) | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthetic (e.g. Novocaine) | <input type="checkbox"/> Others: _____ |

Signed By _____

Current Date
