

PERSONAL DATA

Patient Name: _____
Last First

M F Birthday: _____ Age: _____

Spouse: _____ Children _____

Father (If Child): _____ Mother (If Child): _____

Address: _____
Street

City State Zip

Phone: Home: _____ Work: _____

School Attending: _____

EMPLOYMENT

Occupation: _____

Employee Name (or Father if other than patient):

Business Telephone: _____

Employer Name: _____

Employer Address: _____

Supervisor Name: _____

Health Care Coordinator: _____

Insurance Company Name: _____

Insurance Company Address: _____

Subscriber's S.S. #: _____

Insurance I.D.#: _____

Plan: _____

Person Responsible (If other than parent): _____

Address: _____
Street

City State Zip

Whom may we thank for referring you: _____

Other family members who are patients: _____

Occupation: _____

Employee Name (or Father if other than patient):

Business Telephone: _____

Employer Name: _____

Employer Address: _____

Supervisor Name: _____

Health Care Coordinator: _____

Insurance Company Name: _____

Insurance Company Address: _____

Subscriber's S.S. #: _____

Insurance I.D.#: _____

Plan: _____

DENTAL HEALTH HISTORY

How long since your last dental visit? _____

What was done at that time? _____

What is the reason you left your last dentist? _____

1. What can I do for you? _____

2. Are you having any discomfort at this time? Yes No

3. Do you have any discomfort due to hot/cold/chewing/sweets? Yes No
If so, where? _____

4. Does food catch between your teeth? Yes No
If so, where? _____

5. Do your gums ever bleed, feel irritated, tender or swollen? Yes No
If so, where? _____

6. Are you aware that you have TMJ problems? Yes No

7. Are you aware of clenching or grinding your teeth during the night or day?
 Yes No _____

8. Do you have headaches? Yes No _____

9. How often do you brush and floss your teeth? _____

10. Have you ever had any problems with a local anesthetic? Yes No

11. Do you have any teeth missing? Yes No
Have they ever been replaced? Yes No

12. Have you had any serious previous dental problems? Yes No

13. Are you completely happy with the appearance of your teeth? Yes No

Alignment Yes No

Shape Yes No

Color Yes No

Old Fillings Yes No

Spaces Yes No

Previous dental work Yes No

MEDICAL HISTORY

1. Who can we notify in case of emergency? _____

Phone: _____

2. Have you been hospitalized or had a serious illness in the past five years?
 Yes No If so, what? _____

3. Have you been under the care of a physician during the past five years?
 Yes No If so, what is the condition being treated? _____

4. Name and address of your physician: _____

5. Are you taking any medication at this time? Yes No
If so, what are they and for what? _____

6. Are you allergic to penicillin, codeine or any other medications? Yes No
If so, which medications? _____

7. Do you smoke? Yes No

8. Do you have or have you had any of the following:

Heart trouble

Tuberculosis

Congenital heart lesions

Arthritis

Heart murmur

Stroke

Mitral valve prolapse

Epilepsy

Rheumatic Fever

Psychiatric treatment

Blood pressure problems

Sinus trouble

Anemia

Venereal disease

Excessive bleeding problems

Hepatitis A or B

Asthma

AIDS

Fainting spells

AIDS Related Complex

Diabetes

9. Have you had a tumor or growth removed? Yes No

10. (Women) Are you pregnant now? Yes No

Blood Pressure S/ _____ D/ _____

Date: Signature: _____

I acknowledge the above is correct to the best of my knowledge.