

Although dental personnel primarily treat the area around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Last Name _____ First _____ Middle _____ Date _____
 Date of Birth ____ / ____ / ____ Name of Physician _____ Physician's Phone # _____
 Emergency Contact _____ Relationship _____ Phone _____

1. When was your last physical examination? Date: _____
2. Are you under a physician's care now? Yes No Explain: _____
3. Have you ever been hospitalized or had a major operation? Yes No Explain: _____
4. Have you ever had a serious neck or head injury? Yes No Explain: _____
5. Are you taking any medications, pills, or drugs? Yes No Please List: _____
6. Are you taking any non-prescription drugs/supplements? Yes No Please List: _____
7. Have you taken bisphosphonates? (ie: Fosamax, Boniva, Zometa) Yes No If yes, how long: _____
8. Do you use tobacco? Yes No Daily Usage: _____
9. Alcohol Consumption: Glasses per week: 1-4 5-8 9+
10. Women: Are you Pregnant? Nursing? Taking oral contraceptives?
11. Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other If other, please explain: _____

12. DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Parathyroid Disease |
| <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Recent Weight Loss / Gain |
| <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> HPV | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial Joint Date: _____ | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting / Dizziness | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Frequent Headache | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack / Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Sjogrens Syndrome |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mental Health Disorder | <input type="checkbox"/> STD's |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Pace Maker | Type: _____ | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Osteopenia/Osteoporosis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Crohn's | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Herpes | <input type="checkbox"/> Panic Attack | <input type="checkbox"/> Ulcers |

13. Other items to mention, or comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____

MEDICAL HISTORY UPDATE

CHANGES IN HEALTH: _____

MEDICATIONS / TREATMENT: _____

DATE: _____ SIGNATURE: _____

CHANGES IN HEALTH: _____

MEDICATIONS / TREATMENT: _____

DATE: _____ SIGNATURE: _____

CHANGES IN HEALTH: _____

MEDICATIONS / TREATMENT: _____

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MEDICATIONS / TREATMENT: _____

DATE: _____ SIGNATURE: _____

CHANGES IN HEALTH: _____

MEDICATIONS / TREATMENT: _____

DATE: _____ SIGNATURE: _____

CHANGES IN HEALTH: _____

MEDICATIONS / TREATMENT: _____

DATE: _____ SIGNATURE: _____

Today's Date: _____

Patient _____
Last Name First Name Middle Initial I prefer to be called

PLEASE CHECK PREFERRED FORM OF CONTACT:

Home Phone _____ Cell Phone _____

Business Phone _____ E-Mail _____

Home Address _____

Sex: Male Female Age ____ Date of Birth ____ / ____ / ____ Single Married Divorced Separated

Employed By _____ Occupation _____

Business Address _____

Spouse's Name _____

Spouse Employed By _____ Occupation _____

Who is Responsible for this Account? _____ Relationship to Patient _____

In case of emergency, who should be notified? _____ Phone # _____

Whom should we thank for recommending us? _____

PRIMARY DENTAL INSURANCE COMPANY _____ Group # _____ Union/Local # _____

Address of Insurance Company _____

Social Security # _____ Spouse's Social Security # _____

Employee/Subscriber _____ Date of Birth ____ / ____ / ____

Relationship to Patient: Self Spouse Parent

Employer Name & Address _____

SECONDARY INSURANCE COMPANY _____ Group # _____ Union/Local # _____

Address of Insurance Company _____

Employee/Subscriber _____ Date of Birth ____ / ____ / ____

Relationship to Patient: Self Spouse Parent

Employer Name & Address _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits, for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Patient or Authorized Signature _____

Name _____

Date _____

1. When was your last dental visit? _____
2. How often do you see the dentist? _____
3. Do any of the following cause you discomfort? Hot Cold Chewing Sweets
4. How often do you...
Brush your teeth? _____
Floss? _____
Use Mouthwash? _____
5. Do your gums bleed while brushing or flossing? Yes No
6. Do your gums feel tender or swollen? Yes No
7. Have you been treated for periodontal (gum) disease? Yes No If yes, when? _____
8. Do you clench or grind your teeth? Yes No
9. Do your jaws ever...
 Feel tired or ache? Click or pop?
10. Can you chew on both sides of your mouth? Yes No
Comfortably? Yes No
11. Do you have frequent...
Headaches? Yes No
Earaches? Yes No
Neck or shoulder pain? Yes No
12. Have you ever had orthodontic treatment (braces)? Yes No If yes, when? _____
13. Do you have any loose teeth? Yes No
14. Do you have any noticeable wear on your teeth? Yes No
15. Do you have any teeth that trap food? Yes No
16. Do you have any cracked or broken teeth? Yes No
17. Do you have any missing teeth? Yes No
Have they been replaced? Yes No
If so, how? Fixed Bridge Removable Partial Full Denture Dental Implant
Are you comfortable with the replacement? Yes No
Please describe: _____
18. Have you ever whitened your teeth? Yes No

Name _____

Date _____

1. Do you like your smile? Yes No

2. Do you wish your teeth were whiter? Yes No

3. Do you feel you show too many or too few teeth when you smile? Yes No

4. Do you like the way your teeth are shaped? Yes No

If no, please explain: _____

5. Are you satisfied with the way your gums look? Yes No

6. Do you think you show too much gum tissue when you smile? Yes No

7. Do you have any other thoughts or comments regarding your smile?

If yes, please explain: _____

8. Would you like to discuss options to enhance your smile? Yes No

Name _____

Date _____

Who may we thank for referring you to our office? _____

1. Are you having any discomfort or problems with your teeth?

Yes No If yes, please explain: _____

2. When was the last time you saw your dentist? _____

3. Why did you leave your last dentist? _____

4. Was there anything in particular that you liked about your previous dentist or dental visits?

5. Was there anything in particular that you didn't like about your previous dentist or dental visits?

6. What do you consider to be the most important factor in making sure your dental visit is a positive one?

7. What are your goals and desires regarding your dental health? _____

8. Do you have any particular concerns about your dental care? _____

Notes: _____
