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MEDICAL HISTORY

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:

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

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PATIENT REGISTRATION

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 ______________________________

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DENTAL HEALTH EVALUATION

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

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SMILE EVALUATION

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

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NEW PATIENT INTERVIEW

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: ______________________________