



PATIENT INFORMATION

*Welcome to our office! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.*

Patient's name _____	Preferred name _____	Birth date _____
If minor, parents names _____	Cell phone _____	Email _____
Mailing address _____	City _____	State _____ Zip _____
Employer _____	Occupation _____	Work phone _____
Spouse's name _____	Spouse's employer _____	☐ Unmarried
Whom may we thank for referring you to our office? _____		☐ Phonebook
BILLING, CREDIT, AND INSURANCE INFORMATION: ☐ Not covered by dental insurance		
Your Social Security number: _____		Dental Insurance Co. _____ Group number _____
Covered by spouse's insurance? ☐ yes ☐ no		
Spouse's dental insurance company _____		Group number _____
Spouse's birthday _____		Social Security number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ☐ Cancer or tumor
- ☐ Heart ailment or angina
- ☐ Heart murmur, mitral valve prolapse, heart defect ☐
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Artificial joint or valve
- ☐ High or low blood pressure
- ☐ Pacemaker
- ☐ Tuberculosis or other lung problems
- ☐ Kidney disease
- ☐ Hepatitis or other liver disease
- ☐ Alcoholism
- ☐ Blood transfusion
- ☐ Diabetes
- ☐ Neurologic condition
- ☐ Epilepsy, seizures, or fainting spells
- ☐ Emotional condition
- ☐ Arthritis
- ☐ Herpes or cold sores
- ☐ AIDS or HIV positive
- ☐ Migraine headaches or frequent headaches ☐
- ☐ Anemia or blood disorders
- ☐ Abnormal bleeding after extractions, surgery, or trauma ☐
- ☐ Hay Fever or sinus trouble
- ☐ Allergies or hives
- ☐ Asthma

Do you smoke or use chewing tobacco? ☐ yes ☐ no

Are you allergic to, or have you reacted adversely to any of the following?

- ☐ Latex materials
- ☐ Penicillin or other antibiotics
- ☐ Local anesthetics ("Novocain")
- ☐ Codeine or other narcotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Aspirin
- ☐ Other: _____

Are you taking any of the following?

- ☐ Aspirin
- ☐ Anticoagulants (blood thinners)
- ☐ Antibiotics or sulfa drugs
- ☐ High blood pressure medicine
- ☐ Antidepressants or tranquilizers
- ☐ Insulin, Orinase, or other diabetes drug
- ☐ Nitroglycerin
- ☐ Cortisone or other steroids
- ☐ Osteoporosis (bone density) medicine
- ☐ Other: _____

Women:

- ☐ May be pregnant
- Expected delivery date: _____
- ☐ Taking hormones oral contraceptives

Name of your physician: _____

Do you have any disease, condition, or problem not listed above? _____

Please add anything else you would like us to know about: _____

DENTAL HEALTH HISTORY

Have you had problems with previous dental treatment? _____ Do
you gag easily? _____

Do you wear dentures (if yes, how long)? _____ Do
your gums bleed easily? _____

Are you dissatisfied with the appearance of your teeth? _____ How
often do you brush? _____

How often do you floss? _____

Do you clench or grind your jaws frequently? _____

Do you have any jaw symptoms or headaches upon awaking in the morning? _____

Signature of patient (or parent) _____ Date _____