WELCOME

1 About You

Today's Date: ______

Name: ______ LAST FIRST MI MR MRS MS DR

I prefer to be called: ______ ❑ Male ❑ Female

Birthdate: ___/___/___ Age: ______ SS #: ______

Home Address: ______ APT / CONDO #

______ CITY / STATE ZIP

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home #: ______ Pager / Other #: ______

WK #: ______ Ext ______ DL #: ______

E-mail ______

Employer: ______

Employer's Address: ______

How long there? ______ Occupation: ______

Where & when are best times to reach you? ______

Whom may we Thank for referring you? ______

Other family members seen by us: ______

Previous / Present Dentist: ______ (Please Circle)

Last Visit Date: ______

2 Dental History

Why have you come to the dentist today? ______

Are you currently in pain? ❑ Yes ❑ No

Have you ever had a serious / difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

How many times a week do you floss? ______

How many times a day do you brush? ______

Type of bristles? ❑ Hard ❑ Medium ❑ Soft

3 Medical History

Your current physical health is ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please Explain: ______

Are you taking any prescription / over-the-counter drugs? ❑ Yes ❑ No

Please list each one: ______

For Women—Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Wk # ______

Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems?

Y N Heart Attack / Stroke
Y N Cancer / Chemotherapy
Y N Heart Murmur
Y N Rheumatic Fever
Y N HIV+ / AIDS
Y N Heart Surgery / Pacemaker
Y N Shingles
Y N Mitral Valve Prolapse
Y N Kidney Problems
Y N Artificial Bones / Joints
Y N Artificial Valves
Y N Sinus Problems
Y N High / Low Blood Pressure
Y N Fever Blisters
Y N Emphysema / Glaucoma
Y N Psychiatric Problems
Y N Epilepsy / Seizures / Fainting Spells
Y N Diabetes / Tuberculosis (TB)
Y N Drug / Alcohol Abuse
Y N Venereal Disease
Y N Hemophilia / Abnormal Bleeding
Y N Ulcers / Colitis
Y N Congenital Heart Defect
Y N Anemia / Radiation Treatment
Y N Asthma / Arthritis
Y N Difficulty Breathing
Y N Hospitalized for any reason
Y N Hepatitis
Y N Blood Transfusion
Y N Severe / Frequent Headaches

Please list any medical condition(s) that you have ever had: ______

Are you allergic to any of the following drugs?

Y N Penicillin
Y N Aspirin
Y N Erythromycin
Y N Tetracycline
Y N Dental Anesthetics
Y N Codeine
Y N Latex
Y N Other

Please list any other drugs that you are allergic to: ______

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature ______ Date ______