Patient Information

Date_____ **Sex M F Age**_____

SS#_____**DOB**_____

Patient Name_____

Address_____

City_____**State**_____**Zip**_____

E-mail_____

Home _____**Work**_____

Cell_____ **Marital Status**_____

Contact Method (please circle) Email Phone Text

Employer/School_____

Spouse/Parent or Guardian_____

Emergency Contact_____

Emergency Contact Phone #_____

Dental History

Last dental visit_____

Former Dentist_____

Last X-rays_____

Mark if you have or had the following:

Bad Breath Sensitivity to Cold

Bleeding Gums Sensitivity to Hot

Chew on one side Sensitivity to Sweets

Tobacco Use Sores or Growths

Type_____ in your mouth

Frequency_____

Clicking/Popping in Jaw Dry Mouth

Periodontic Treatment Orthodontic treatment

How often do you floss?___ Brush?_____

HEALTH INFORMATION: Please circle those that apply.

AIDS/HIV
Anemia
Arthritis
Artificial Joints
Asthma
Blood Disease
Blood Thinner
Cancer
Chemotherapy
Daily Asprin Regiment
Diabetes
Dizziness
Emphysema
Epilepsy
Excessive Bleeding
Fearful or anxious
Glaucoma
Hay Fever/Allergies
Head Injuries
Heart Condition
Heart Surgery
Heart Murmur
Heart Valve Replacement
Hepatitis Type___
High Blood Pressure
Low Blood Pressure
Kidney Disease
Liver Disease
Metal Allergies
Migraine Headaches
Mitral Valve Prolapse
Pace Maker
Currently Pregnant
Due Date:_____
Radiation Treatment
Rheumatic Fever
Sinus Problems
Stomach Problems
Stroke
Tuberculosis
Ulcers
Codeine Allergy
Penicillin Allergy
Latex Allergy
Adverse reaction to dental anesthetics?
Abnormal Bleeding ?
Medication allergies?
Please list_____
_____
_____
_____
Been advised to take antibiotics prior to dental treatment for preventative reasons?

Please list all drugs that you are taking? (Prescription, OTC, Herbal)

_____
_____
_____
_____
_____
_____
_____
_____

Are you Happy with the appearance of your smile?
Yes No

Do you wish your teeth were whiter?
Yes No

Are you now under the care of a physician for an on-going or chronic health problem? Yes No

Name of Physician_____ Phone:_____

To the best of my knowledge, all the preceding information is true and correct. If I ever have any changes in my medical or health status, I promise to notify the doctor at my next appointment.

_____

Signature of patient, parent or guardian Date: