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PATIENT INFORMATION

Today's Date:_____
Patient:_____ Parent/Guardian(If Minor)_____
Address_____ City/State_____ Zip_____
HomePhone(__)_____ Work(__)_____ Cell(__)_____
DateOfBirth:_____ SS#(parent if minor)_____ Sex M/F
Height_____ Weight_____ Email address_____
Occupation_____ Marital Status_____ Hobbies_____
Who May We Thank For Referring You To Our Office?_____

DENTAL INSURANCE INFORMATION

Name of Policyholder:_____ Policyholders's SS#:_____ DOB_____
Policyholder's Employer:_____ Insurance Company_____ Group#_____
Insurance Company Phone #_____

MEDICAL HISTORY

My health is:(circle one) Excellent / Good / Fair / Poor **Date of last physical:**_____
Have you been hospitalized or under a physician's care in the last 2 years? Yes / No If yes, explain:_____
Have you taken diet pills? Yes / No If Yes, What kind?_____ How long?_____
List any prescription or over the counter medications you are using:_____
_____
Do You: Smoke? Yes/ No Packs per day___ **Drink Alcohol**? Yes / No Drinks Per Day/Week_____
Recreational drug use? Yes/ No Type & Frequency_____
Surgical Procedures: Type and Date_____
General anesthesia? Yes / No Sedation Yes / No
Are you allergic (i.e. itching, rash, swelling of hands/feet/eyes) to penicillin, mycins, codeine, aspirin, anesthetics, sulfas, others?_____
Have you taken any bisphosphonates or been treated for bone disease? Yes/No If yes, describe treatment
_____

Check if you have or have had any of the following:

__Heart Failure
__Heart Disease/Attack
__Angina Pectoris
__High Blood Pressure
__Heart Murmur
__Rheumatic Fever
__Congenital Heart Lesions
__Scarlet Fever
__Artificial Heart Valve
__Heart Pace Maker
__Heart Surgery
__Artificial Joint
__Stroke

__Emphysema
__Cough
__Tuberculosis
__Asthma
__Allergies/Hives
__Diabetes
__Thyroid Disease
__X-ray/Cobalt Treat
__Chemotherapy
__Arthritis
__Rheumatism
__Cortisone treatment
__Other_____

__Kidney trouble
__Sinus Problems
__Substance Abuse
__Venereal Disease
__Psychiatric Care
__Nervousness/Anxiety
__Epilepsy
__Seizures
__Fainting
__Dizzy spells
__Pain/Swelling in joints
__Pain in Jaw Joints

__Bruise Easily
__Prolonged Bleeding
__Sickle Cell Anemia
__Anemia
__Blood Transfusion
__Hepatitis Type___
__Hemophilia
__HIV/AIDS
__Liver disease
__Yellow Jaundice
__Ulcers
__Glaucoma

WOMEN ONLY:

Are You Pregnant? Yes / No Due Date?_____ Complications, if any:_____
Do you plan on becoming pregnant in the next year? Yes / No Using Oral Contraceptives? Yes / No
Do you experience yeast infections? Yes / No Frequency:_____
Have You Reached Menopause? Yes / No

FAMILY MEDICAL HISTORY

Any disease(s) in your immediate family? Yes / No
If yes, explain:_____

DENTAL/ PERIODONTAL HISTORY

Are you having pain/discomfort at this time?_____
When was your last dental visit?_____ When was your last cleaning?_____
Any complications with previous dental treatment?_____

I brush ___ times a day with a (circle one) soft / medium / hard toothbrush.
Do you use an electric toothbrush? Yes / No Do you use fluoride? Yes / No
I floss ___ times a day in the (circle) morning / afternoon / evening.

Have you ever been treated for periodontal disease? Yes / No If yes, when? _____
Do you ever avoid chewing due to pain? Yes / No
Are you aware of clenching or grinding? Yes / No
Do you have difficulty opening your mouth? Yes / No
Do your gums bleed when you brush your teeth? Yes / No
Have you noticed bad breath? Yes / No
Has a member of your family ever been treated for periodontal disease? Yes/ No Who?_____

ADDITIONAL INFORMATION_____

_____

_____ _____
Signature of Patient/Guardian Doctor's Signature