# Patient Information

**Welcome to our office. We appreciate the confidence you place in us to provide dental services. To assist in serving you, please complete the following forms. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.**

Patient Name _____ DOB: _____ Sex: _____ Age: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Home phone: _____ Cell: _____ E-Mail: _____

SS#: _____ Employer: _____ Bus. Phone: _____

Marital Status (Circle One): Single Married Divorced Other Spouse Name: _____

Spouse Phone Number: _____ Emergency Phone# (other than spouse): _____

Primary Dental Insurance: _____ ID #: _____ Group#: _____

Secondary Dental Insurance: _____ ID #: _____ Group#: _____

Subscriber's Name: _____ Date of Birth: _____ SS#:_____

Name of Medical Physician: _____ Date of last visit to medical physician: _____

Name of Previous Dentist: _____ Date of last cleaning: _____

Referred to us by: _____ Preferred Method of Contact? Home ☐ Cell ☐ Email ☐

## DENTAL HEALTH HISTORY

| | YES | NO |
|---|---|---|
| Are you apprehensive about dental treatment? | ☐ | ☐ |
| Have you had problems with previous dental treatment? | ☐ | ☐ |
| Do you gag easily? | ☐ | ☐ |
| Do you wear Dentures? | ☐ | ☐ |
| Does food catch between your teeth? | ☐ | ☐ |
| Do you have difficulty in chewing your food? | ☐ | ☐ |
| Do you chew on only one side of your mouth? | ☐ | ☐ |
| Do you avoid brushing because of pain? | ☐ | ☐ |
| Do your gums bleed easily? | ☐ | ☐ |
| Do you bleed when you floss? | ☐ | ☐ |
| Do your gums feel swollen or tender? | ☐ | ☐ |
| Have you ever noticed slow-healing sores about your mouth? | ☐ | ☐ |
| Are your teeth sensitive? | ☐ | ☐ |
| Do you feel twinges of pain when your teeth come in contact with: | | |
| Hot foods or liquids? | ☐ | ☐ |
| Cold foods or liquids? | ☐ | ☐ |
| Sours? | ☐ | ☐ |
| Sweets? | ☐ | ☐ |
| Are you dissatisfied with the appearance of your teeth? | ☐ | ☐ |
| Do you prefer to save your teeth? | ☐ | ☐ |
| Do you want complete dental care? | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| How often do you brush? _____ | | |
| How often do you floss? _____ | | |
| Does your jaw make noise so that it bothers you? | ☐ | ☐ |
| Do you clench or grind your jaw frequently? | ☐ | ☐ |
| Does your jaw ever feel tired? | ☐ | ☐ |
| Does your jaw get stuck so that you can't open it freely? | ☐ | ☐ |
| Does it hurt when you chew or open wide to take a bite? | ☐ | ☐ |
| Do you have earaches or pain in front of ears? | ☐ | ☐ |
| Do you have any jaw symptoms or headaches upon awakening in the morning? | ☐ | ☐ |
| Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities? | ☐ | ☐ |
| Do you find jaw pain or discomfort extremely frustrating or depressing? | ☐ | ☐ |
| Do you take medications or pills for discomfort (pain relievers, muscle relaxants, antidepressants? | ☐ | ☐ |
| Do you have a temporomandibular (jaw) disorder (TMD)? | ☐ | ☐ |
| Do you have pain in the face, cheeks, jaws, joints, throat or temple? | ☐ | ☐ |
| Are you able to open your mouth as far as you want? | ☐ | ☐ |
| Are you aware of an uncomfortable bite? | ☐ | ☐ |
| Have you had a blow to the jaw (trauma)? | ☐ | ☐ |
| Have you had your wisdom teeth removed? | ☐ | ☐ |

# MEDICAL HEALTH HISTORY

**Do you have, or have you had, any of the following?**

| | Yes | No |
|---|---|---|
| Heart Problems | ☐ | ☐ |
| Chest Pain | ☐ | ☐ |
| Shortness of breath | ☐ | ☐ |
| Blood pressure problem | ☐ | ☐ |
| Heart murmur | ☐ | ☐ |
| Heart valve problem | ☐ | ☐ |
| Taking heart medication | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ |
| Pacemaker | ☐ | ☐ |
| Artificial heart valve | ☐ | ☐ |
| Blood Problems | ☐ | ☐ |
| Easy Bruising | ☐ | ☐ |
| Frequent nosebleeds | ☐ | ☐ |
| Abnormal bleeding | ☐ | ☐ |
| Blood disease (anemia) | ☐ | ☐ |
| Ever require a blood transfusion? | ☐ | ☐ |
| Allergy Problems | ☐ | ☐ |
| Hay fever | ☐ | ☐ |
| Sinus Problems | ☐ | ☐ |
| Skin rashes | ☐ | ☐ |
| Taking allergy medication | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Intestinal Problems | ☐ | ☐ |
| Ulcers | ☐ | ☐ |
| Weight gain or loss | ☐ | ☐ |
| Special diet | ☐ | ☐ |
| Constipation/Diarrhea | ☐ | ☐ |
| Kidney or bladder problems | ☐ | ☐ |
| Bone or Joint Problems | ☐ | ☐ |
| Arthritis | ☐ | ☐ |
| Back or neck pain | ☐ | ☐ |
| Joint replacement | ☐ | ☐ |
| Osteoporosis/Osteopenia | ☐ | ☐ |
| Do you take medications for Osteoporosis/ Osteopenia? | ☐ | ☐ |
| If so, please list medications _____ | | |
| _____ | | |
| Fainting Spells, Seizures, or Epilepsy | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Frequent or severe headaches | ☐ | ☐ |
| Thyroid problems | ☐ | ☐ |
| Persistent cough or swollen glands | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Diabetes | ☐ | ☐ |
| Urinate more than 6 times a day | ☐ | ☐ |
| Thirsty or mouth is dry much of time | ☐ | ☐ |
| Family history of diabetes | ☐ | ☐ |
| Tuberculosis or other respiratory disease | ☐ | ☐ |
| Do you drink alcohol? | ☐ | ☐ |
| If so, how much? _____ | | |
| Do you smoke? | ☐ | ☐ |
| If so, how much? _____ | | |
| Hepatitis, jaundice, or liver trouble | ☐ | ☐ |
| HIV-positive/AIDS | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Do you wear contact lenses? | ☐ | ☐ |
| History of head injury? | ☐ | ☐ |
| Epilepsy or other neurological disease? | ☐ | ☐ |
| History of alcohol or drug abuse? | ☐ | ☐ |
| Do you have any disease, condition, or problem previously that you feel we should know about? | ☐ | ☐ |
| If so, please describe:_____ | | |
| _____ | | |

**During the past 12 months, have you taken any of the following?**

| | | |
|---|---|---|
| **Antibiotics or sulfa drugs** | ☐ | ☐ |
| **Anticoagulants (e.g., Coumadin)** | ☐ | ☐ |
| **High blood pressure medicine** | ☐ | ☐ |
| **Tranquilizers** | ☐ | ☐ |
| **Insulin, Orinase, or similar drug** | ☐ | ☐ |
| **Aspirin** | ☐ | ☐ |
| **Digitalis or drugs for heart trouble** | ☐ | ☐ |
| **Nitroglycerin** | ☐ | ☐ |
| **Cortisone (steroids)** | ☐ | ☐ |
| **Natural remedies** | ☐ | ☐ |
| **Nonprescription drug/supplements** | ☐ | ☐ |

**Please list any medications you are presently taking**

_____

_____

**WOMEN**

| | | |
|---|---|---|
| **Are you taking contraceptives?** | | |
| **Are you pregnant?** | ☐ | ☐ |
| **If so, expected delivery date: _____** | ☐ | ☐ |
| **Are you nursing?** | | |
| **Have you reached menopause?** | ☐ | ☐ |
| **If so, do you have any symptoms?** | ☐ | ☐ |

_____

| Are you allergic to any of the following? | Yes | No |
|---|---|---|
| Local anesthetics ("Novocaine") | ☐ | ☐ |
| Penicillin or other antibiotics | ☐ | ☐ |
| Sulfa drugs | ☐ | ☐ |
| Barbiturates, sedatives, or sleeping pills | ☐ | ☐ |
| Aspirin, Acetaminophen, or Ibuprofen | ☐ | ☐ |
| Codeine, Demerol, or other narcotics | ☐ | ☐ |
| Reaction to metals | ☐ | ☐ |
| Latex or rubber dam | ☐ | ☐ |
| Other _____ | ☐ | ☐ |

Notes: _____

_____

_____

Patient/Parent Signature:_____

Dentist Initial: _____

## Office Policies and Procedures

**In order to better serve you in the most consistent, efficient and transparent way possible, we have established the following office policies. Please place your initials by each to indicate that you have read and understood them.**

Payment and/or copayment is required in full at the time services are rendered. If you have dental insurance coverage, please be advised that the co-payment requested for services rendered is only an estimate based on information that was given to us by your insurance company. Initials _____

If you have any questions about your insurance coverage, please let us answer them before treatment begins. Otherwise, the assumption will be that you are familiar with your dental plan coverage and limitations. Initials _____

The doctor and hygienist have reserved your appointment time slot ESPECIALLY for you. A minimum of 24 hours' notice is required for all appointment changes or cancellations in order to avoid a $50 broken appointment fee. Initials _____

There will be a $35.00 fee for each returned (bad) check that we receive. Initials _____