Answers to the following questions are for our records only and will be kept confidential. Date ____________________

Patient Information

Your Name ________________________________ Nickname ____________________ SS# ______ - ______ - ________

Birth Date ______ / ______ / _________ Age _____ Height _____ Weight _____ Sex: M F Driver's License # ____________________

Address ________________________________ City ____________________ State _____ ZIP _______________

Home Phone ( ) Cell Phone ( ) Email ______________________@_______________

Occupation ____________________ Employer ____________________ Work Phone ( )

Spouse's Name ____________________ Parent/Guardian for Minor Patient ____________________

Emergency Contact ________________________________ Phone ( ) Relationship _______________

Responsible Party (if different from patient)

Name ________________________________ Relationship to Patient: ☐ Spouse ☐ Parent ☐ Guardian

Address ________________________________ City ____________________ State _____ ZIP _______________

Home Phone ( ) Cell Phone ( ) Email ______________________@_______________

Employer ________________________________ Work Phone ( )

Dental Insurance

Policyholder's Name ____________________ Birth Date _____ / _____ / ___________ SS# ____ - _____ - ___________

Insurance Company ____________________ ID# ____________________ Group No. ____________________

Health History

For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out areas which pertain to you. **All information is private and confidential.**

Dental History

Your Dentist ________________________________

City ________________________________

How Long _______________ Last Dental Visit _______________

Last Cleaning _______________ Last full mouth x-rays __________

Do you want to keep your teeth?

☐ Yes, no matter what ☐ Yes, if it's not too much trouble

☐ I'm not sure ☐ It doesn't matter

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

☐ mouth discomfort ☐ bad dental experience

☐ previous deep cleaning ☐ fear of dental treatment

☐ previous gum surgery ☐ sensitive teeth (hot, cold, sweets)

☐ swollen/tender gums ☐ bad breath or bad taste

☐ bleeding gums ☐ gum abscess/pus

☐ loose/loosening teeth ☐ prior braces

☐ any complications from prior anesthesia

☐ any complications from prior dental/surgical treatment

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Medical History

Any health problems or medications that you may be taking can have an effect on your oral and periodontal health, so please review this portion carefully and completely fill out which areas that pertain to you. **All information is private and confidential.**

List your current physician(s):

________________________ Type ______________ Phone ( ) How long? __________

________________________ Type ______________ Phone ( ) How long? __________

Date of last physical exam including bloodwork ____________ Findings ______________________

Have there been any changes in your general health last year? ☐ YES ☐ NO If YES, please explain: ______________

Are you under a physician's care now? ☐ YES ☐ NO If YES, please explain: ______________

Have you ever been hospitalized or had a major operation? ☐ YES ☐ NO If YES, please explain: ______________

Have you ever had excessive bleeding that required treatment? ☐ YES ☐ NO If YES, please explain: ______________

Do you have a family history of diabetes in your family? ☐ YES ☐ NO If YES, please explain: ______________

Are you on a special or restricted diet? ☐ YES ☐ NO If YES, please explain: ______________

Have you had a history of alcohol or illicit drug abuse? ☐ YES ☐ NO If YES, please explain: ______________

Do you currently use tobacco products (smoke, chew, dip) ☐ YES ☐ NO If YES: How much? __________ How long? __________

For females: Are you

Pregnant/Trying? ☐ YES ☐ NO Taking oral contraceptives? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO Post-menopause? ☐ YES ☐ NO

Please list all medications you are taking including over-the-counter drugs, or supplements:

Do you or have you ever used methadone? ☐ YES ☐ NO If YES, please explain: ______________

Do you or have you ever used narcotics for chronic pain? ☐ YES ☐ NO If YES, please explain: ______________

Do you take blood thinners, including aspirin? ☐ YES ☐ NO If YES, please explain: ______________

Do you take medication for osteoporosis? ☐ YES ☐ NO If YES, which one? ______________

Route: ☐ oral ☐ shot ☐ IV infusion

Frequency: ☐ daily ☐ every ___ months

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Tetracycline	☐ Clindamycin	☐ Versed	☐ Tylenol	☐ Codeine	☐ Ibuprofen
☐ Local anesthetics	☐ Amoxicillin	☐ Doxycycline	☐ Sulfa drugs	☐ Valium	☐ Halcion	☐ Norco/Lortab	☐ Latex

☐ Other(s) ______________________ If yes, what sort of reaction? ______________________

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

Heart Disease	☐ Yes ☐ No	Swollen limbs/ankles	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Cortisol imbalance	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Artificial joints	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	HIV/AIDs	☐ Yes ☐ No
Chest pain	☐ Yes ☐ No	Kidney/bladder trouble	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No	Thyroid disease	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Dialysis	☐ Yes ☐ No
Low blood pressure	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Heart murmur	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Venereal disease	☐ Yes ☐ No	Osteoarthritis	☐ Yes ☐ No
Congenital heart defect	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Artificial heart valve	☐ Yes ☐ No	Epilepsy or seizures	☐ Yes ☐ No	Sinus infections	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	Frequent headaches	☐ Yes ☐ No	Hay fever	☐ Yes ☐ No	GI disorders	☐ Yes ☐ No
Scarlet fever	☐ Yes ☐ No	Fainting/dizzy spells	☐ Yes ☐ No	Cancer/tumors	☐ Yes ☐ No	Herpes	☐ Yes ☐ No
Rheumatic fever	☐ Yes ☐ No	Sickle cell anemia	☐ Yes ☐ No	Radiation	☐ Yes ☐ No	Psychiatric care	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Chemotherapy	☐ Yes ☐ No	Anxiety/Depression	☐ Yes ☐ No

Do you have any medical condition/diseases not listed on above that we should know about? ☐ Yes ☐ No

If yes, please explain: ______________________________________

I attest that to the best of my knowledge, the information provided above is accurate and complete. I understand that providing incorrect or omitting information can be dangerous to my (or the patient's) health. If I ever have any changes in my health or to medications, it is my responsibility to inform the office.

______________________________ ______________________________

Patient, Parent, or Guardian's Signature Date Doctor's Signature Date