PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. 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: _____ Date of birth: _____ Sex: _____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (if different): _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ E-mail: _____ Driver's license #: _____ State: _____

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

Spouse's name & phone #: _____ Emergency phone # (other than spouse): _____

Primary dental insurance: _____ Group #: _____

Secondary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

Name of your medical doctor: _____ Date of last visit to medical doctor: _____

Name of previous dentist: _____ Date of last visit to dentist: _____

Referred to us by: _____ _____

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 any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores in or 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?	☐	☐
Do you take fluoride supplements?	☐	☐
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 or others?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaw get stuck so that you can't open freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches upon awaking 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 pain or 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 temples?	☐	☐
Are you unable 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)?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐

PATIENT MEDICAL HISTORY

Name: _____ Cell phone: _____ Date: _____

B/P: _____
For office use

Please check yes or no for the following questions:

DENTAL HISTORY

YES	NO	
___	___	Do you have pain in or near your ears?
___	___	Do you have any unhealed injuries or inflamed areas in or around your mouth?
___	___	Have you experienced any growth or sore spots in your mouth?
___	___	Does any part of your mouth hurt when clenched?
___	___	Do your gums bleed?
__	___	Have you had instruction of the correct method for brushing and flossing your teeth?
___	___	Is any part of your mouth sensitive to pressure, heat, cold, or sweets?
		If yes, where? _____
		When were your last full mouth x-rays taken? _____

MEDICAL HISTORY

YES	NO	
___	___	Do you have a heart pacemaker?
___	___	Do you have any artificial heart valves, hip or knee replacements?
___	___	Have you been told by a doctor to pre-med before dental appointment?
___	___	Do you smoke? If yes, how long? _____ How much per day? _____
___	___	Do you drink alcohol? If yes, how often? _____
___	___	Are you allergic to any medications?
___	___	Are you now taking any medications? If yes, please supply list of Rx and Supplements
		_____
		_____
__	___	**Women only:** Are you pregnant? If yes, number of weeks? _____

Have you ever had or been treated for?

YES	NO		YES	NO	
___	___	Heart disease	___	___	Latex sensitivity
___	___	High blood pressure	___	___	Hepatitis (A, B or C)
___	___	Arthritis/Rheumatism	___	___	HIV Positive
___	___	Diabetes (Type 1 or 2)	___	___	Epilepsy or seizures
___	___	Emphysema or asthma	___	___	Fainting or dizzy spells
___	___	Liver disease	___	___	Stomach or intestinal disease
___	___	Kidney disease	___	___	Tuberculosis
			___	___	Cancer

Physician's Name: _____

I have answered all the above questions to the best of my knowledge.
Patient/Guardian Signature: _____ Date: _____