



## PATIENT'S INFORMATION

PATIENT'S NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email address \_\_\_\_\_ Res. Tel. \_\_\_\_\_ Mobile Tel. \_\_\_\_\_

Preferred method of appointment confirmation: Email Telephone Text (Circle All that Apply)

Social Security No. \_\_\_\_\_ D/L # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Marital Status: Single Married Separated Divorced Widowed (Circle One)

Occupation \_\_\_\_\_ Employer Name \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Bus. Tel. \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Social Security No. \_\_\_\_\_ Bus. Tel. \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

### PERSON TO CONTACT IN AN EMERGENCY

Relationship \_\_\_\_\_

Res. Phone ( ) \_\_\_\_\_ Bus. Phone ( ) \_\_\_\_\_

### PARTY RESPONSIBLE FOR PAYMENT OF ACCOUNT

Res. Phone ( ) \_\_\_\_\_ Bus. Phone ( ) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Reason for this visit \_\_\_\_\_

## HEALTH HISTORY

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

### ALL INFORMATION IS PRIVATE AND CONFIDENTIAL

#### ■ DENTAL HISTORY

Your Previous Dentist \_\_\_\_\_ City \_\_\_\_\_ How Long? \_\_\_\_\_

Date of last visit \_\_\_\_\_ Date of last dental cleaning \_\_\_\_\_ Last X-Rays \_\_\_\_\_

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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Mouth Discomfort                       | <input type="checkbox"/> Grind or Clench your teeth              | <input type="checkbox"/> Immediate Relatives with loss of |
| <input type="checkbox"/> Previous Periodontal Treatment         | <input type="checkbox"/> Clicking, Popping or Pain in Jaw Joints | <input type="checkbox"/> Natural Teeth                    |
| <input type="checkbox"/> Orthodontic Treatment                  | <input type="checkbox"/> Bad Dental Experience                   | <input type="checkbox"/> Gum Abscesses                    |
| <input type="checkbox"/> Sensitive Teeth (heat, cold or sweets) | <input type="checkbox"/> Wake with Sore Jaws                     | <input type="checkbox"/> Complications with or Following  |
| <input type="checkbox"/> Gums Bleed when Brushing               | <input type="checkbox"/> Mouth Odor or Bad Taste                 | <input type="checkbox"/> Previous Dental or Oral          |
| <input type="checkbox"/> Loose or Shifting Teeth                | <input type="checkbox"/> Cold Sore or Fever Blister              | <input type="checkbox"/> Surgical Treatment               |
| <input type="checkbox"/> Trouble in Chewing or Speaking         | <input type="checkbox"/> Other Oral Lesions                      | <input type="checkbox"/> Fear of Dental Treatment         |
| <input type="checkbox"/> Bruise Easily                          |  |   |

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**■ MEDICAL HEALTH HISTORY**

1) HOW WOULD YOU DESCRIBE YOUR PRESENT HEALTH?    Excellent    Good    Fair    Poor

2) LIST YOUR CURRENT PHYSICIANS(S):

a) \_\_\_\_\_ Type \_\_\_\_\_ How Long? \_\_\_\_\_  
 b) \_\_\_\_\_ Type \_\_\_\_\_ How Long? \_\_\_\_\_

3) Date of last complete physical exam \_\_\_\_\_ Purpose \_\_\_\_\_  
 Findings \_\_\_\_\_

Circle "NO" or "YES" Explain

4) Are you aware of any changes in your general health in the last year?    NO    YES \_\_\_\_\_  
 5) Have you ever been hospitalized for illness or surgery in the past two years?    NO    YES \_\_\_\_\_  
 6) Have you been under a medical doctor's care during the past two years?    NO    YES \_\_\_\_\_  
 7) Have you ever had excessive bleeding that required special treatment?    NO    YES \_\_\_\_\_  
 8) Is there any history of diabetes in your family?    NO    YES \_\_\_\_\_  
 9) Are you required to restrict your work activity in any way?    NO    YES \_\_\_\_\_  
 10) Are you on a special or restricted diet of any kind?    NO    YES \_\_\_\_\_  
 11) Do you smoke?    NO    YES    How much? \_\_\_\_\_ How Long? \_\_\_\_\_  
 12) Do you use smokeless tobacco?    NO    YES    How much? \_\_\_\_\_ How long? \_\_\_\_\_  
 13) List all medications you are now taking (include all over the counter). \_\_\_\_\_

13) PLEASE CIRCLE ANY OF THE FOLLOWING MEDICATIONS YOU ARE ALLERGIC TO:

Penicillin	Vibramycin	Novacaine	Tylenol	Codeine	Other _____
Erythromycin	Sulfa Drugs	Carbocaine	Aspirin	Ibuprofen	_____
Tetracycline	Keflex	Xylocaine	Anesthetics	Latex	_____

**■ Indicate which of the following you have had or have at present. Circle "NO" or "YES" to each item.**

• Heart Trouble.....NO	YES	• Artificial Joint (Knee, Hip) ..NO	YES	• Cancers or Tumors.....NO	YES
• Heart Disease or Attack .....NO	YES	• Kidney, Bladder Trouble.....NO	YES	• Radiation Treatment.....NO	YES
• Angina .....NO	YES	• Thyroid Disease.....NO	YES	• Chemotherapy.....NO	YES
• High Blood Pressure .....NO	YES	• Emphysema.....NO	YES	• Arthritis/Rheumatism .....NO	YES
• Low Blood Pressure .....NO	YES	• Persistant Cough .....NO	YES	• Glaucoma.....NO	YES
• Heart Murmur .....NO	YES	• Tuberculosis .....NO	YES	• Contact Lenses .....NO	YES
• Rheumatic Fever.....NO	YES	• Asthma.....NO	YES	• Hepatitis .....NO	YES
• Congenital Heart Lesions.....NO	YES	• Hay Fever .....NO	YES	• Liver Disease .....NO	YES
• Artificial Heart Valve .....NO	YES	• Sinus Troubles.....NO	YES	• Jaundice.....NO	YES
• Scarlet Fever.....NO	YES	• Allergies or Hives.....NO	YES	• A.I.D.S.....NO	YES
• Heart Pacemaker .....NO	YES	• Diabetes .....NO	YES	• Blood Transfusion .....NO	YES
• Heart Surgery.....NO	YES	• Frequent Thirst and/or		• Drug or Alcohol Addiction....NO	YES
• Shortness of Breath		Urination.....NO	YES	• Hemophelia .....NO	YES
Upon Mild Exertion .....NO	YES	• Stroke .....NO	YES	• A Nervous Person .....NO	YES
• Require More Than Two		• Epilepsy or Seizures.....NO	YES	• Ulcers .....NO	YES
Pillows to Sleep .....NO	YES	• Frequent Headaches .....NO	YES	• Biosphonates Therapy.....NO	YES
• Ankles Swell .....NO	YES	• Fainting or Dizzy Spells ....NO	YES	• Psychiatric Care.....NO	YES
• Anemia .....NO	YES	• Latex Allergy .....NO	YES	• Unintentional Weight	
• Sickle Cell Disease .....NO	YES	• Osteoporosis.....NO	YES	Gain/Loss .....NO	YES
		• Osteopenia.....NO	YES	• Phen-Pen for Weight Loss...NO	YES

**■ If Female are you:**

Pregnant?.....NO    YES    Through Menopause? .....NO    YES  
 Taking Birth Control Pills?.....NO    YES    Taking Hormone Medication?.....NO    YES

**■ Do you have any medical condition/diseases not listed above that we should know about?**

NO    YES    Explain \_\_\_\_\_

**■ To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or if my medicines change, I will inform the doctor on or before my next appointment without fail.**

\_\_\_\_\_  
 Patient's Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Doctor's Signature

\_\_\_\_\_  
 Date