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Thank you for choosing our office. In order to serve you properly, please answer all questions on BOTH sides, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential.

PATIENT'S NAME \_\_\_\_\_ PREFERRED NAME \_\_\_\_\_

Male  Female Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address \_\_\_\_\_ Email \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone No. (\_\_\_\_) \_\_\_\_\_

Cell Phone No. (\_\_\_\_) \_\_\_\_\_ How should we contact you?  Home  Cell  Work  Email  Text

Patient Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_\_

Spouse Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

**IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?** (Other than someone living with you)

Name \_\_\_\_\_ Home Ph. No. (\_\_\_\_) \_\_\_\_\_ Work Ph. No. (\_\_\_\_) \_\_\_\_\_

Relationship to patient \_\_\_\_\_

**WHOM MAY WE THANK FOR REFERRING YOU TO US?** \_\_\_\_\_

Do you have any hobbies or interests that you would like to share? \_\_\_\_\_

Is there anyone you would like to give us permission to speak to about your dental care? \_\_\_\_\_

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment or amount that my insurance does not cover. \_\_\_\_\_

*Initials*

**Person responsible for payment:** \_\_\_\_\_

**Primary Dental Insurance**

Employee \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group# \_\_\_\_\_

Insurance Phone No. \_\_\_\_\_

Insurance Member ID # \_\_\_\_\_

Subscriber D.O.B. \_\_\_\_\_

**Secondary Dental Insurance**

Employee \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group# \_\_\_\_\_

Insurance Phone No. \_\_\_\_\_

Insurance Member ID # \_\_\_\_\_

Subscriber D.O.B. \_\_\_\_\_

## Dental History

- |   |   |
|---|---|
| Are you having any pain or discomfort? <input type="checkbox"/> Yes <input type="checkbox"/> No                                       | Do you have dry mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Are you nervous about having dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No                               | Do your teeth ever feel loose? <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Have you ever had a bad dental experience? <input type="checkbox"/> Yes <input type="checkbox"/> No                                   | Does food often catch in-between your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No                             |
| Do you experience difficulty / pain when chewing, talking or using your jaw? <input type="checkbox"/> Yes <input type="checkbox"/> No | Do your gums bleed? <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| Do you have noises in your jaw joint? <input type="checkbox"/> Yes <input type="checkbox"/> No  | Have you ever had periodontal (gum) disease? <input type="checkbox"/> Yes <input type="checkbox"/> No                             |
| Does your bite feel uncomfortable or unusual? <input type="checkbox"/> Yes <input type="checkbox"/> No                                | Are your teeth sensitive to cold/heat/sweets? <input type="checkbox"/> Yes <input type="checkbox"/> No                            |
| Have you ever had an injury to your head or jaw? <input type="checkbox"/> Yes <input type="checkbox"/> No                             | Do you take antibiotics for a health condition before each dental visit? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you been treated for a jaw joint problem? <input type="checkbox"/> Yes <input type="checkbox"/> No                               | Previous Dentist's Name and Location: _____   |
| Chief dental concern: _____   | Are you happy with the way your smile looks? <input type="checkbox"/> Yes <input type="checkbox"/> No                             |
| _____   | If not, what would you change? _____  |

## Health History

- |   |  |
|---|--|
| Have you been hospitalized or seen a Medical Doctor in the past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No               | Are you currently taking any prescriptions, over the counter drugs or herbal supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <i>If so, for what condition?</i> _____   | <b><i>If so, please list and include the reason for taking:</i></b> _____  |
| <i>Physician's Name:</i> _____  | _____  |
| <i>Date and reason of last visit:</i> _____   | _____  |
| Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel, etc) <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you take blood thinners? <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Name of and date started? _____   | Name of and date started: _____  |
| WOMEN: Are you pregnant or nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No  | Please list any serious medical condition(s) that you currently have or have had in the past: _____  |
| Do you smoke, vape or use chewing tobacco? (circle one) <input type="checkbox"/> Yes <input type="checkbox"/> No                                |  |

### Please Check any of the following which you have now or have had in the past.

#### No Medical Conditions

- |  |  |  |   |  |
|--|--|--|---|--|
| <input type="checkbox"/> Acid Reflux/GERD/heartburn  | <input type="checkbox"/> Blood Transfusion/Anemia      | <input type="checkbox"/> Radiation Treatment for Cancer      | <input type="checkbox"/> Canker Sores/Cold Sores (circle one) | <input type="checkbox"/> Emphysema               |
| <input type="checkbox"/> Angina Pectoris (Chest Pain)  | <input type="checkbox"/> Sickle Cell Disease           | <input type="checkbox"/> Tuberculosis (TB)                   | <input type="checkbox"/> Fainting/Dizzy Spells                | <input type="checkbox"/> Asthma                  |
| <input type="checkbox"/> Heart Disease/Attack/Stroke   | <input type="checkbox"/> Bruise Easily                 | <input type="checkbox"/> Arthritis/Rheumatism/Lupus          | <input type="checkbox"/> Epilepsy/Seizures                    | <input type="checkbox"/> Depressed Immune System |
| <input type="checkbox"/> Heart Failure   | <input type="checkbox"/> Hemophilia/Blood Disorder     | <input type="checkbox"/> Cortisone Medicine/Steroids         | <input type="checkbox"/> Hay Fever/Sinus Trouble              | <input type="checkbox"/> Organ Transplant        |
| <input type="checkbox"/> High/Low Blood Pressure (circle one)                                  | <input type="checkbox"/> Liver Disease/Yellow Jaundice | <input type="checkbox"/> Venereal Disease/STDs/HPV           | <input type="checkbox"/> Allergies/Hives                      | <input type="checkbox"/> Osteoporosis            |
| <input type="checkbox"/> Congenital Heart Defect   | <input type="checkbox"/> Kidney Failure/Dysfunction    | <input type="checkbox"/> A.I.D.S./H.I.V.                     | <input type="checkbox"/> Shingles                             | <input type="checkbox"/> High Cholesterol        |
| <input type="checkbox"/> Heart Surgery   | <input type="checkbox"/> Thyroid Disease/Condition     | <input type="checkbox"/> Hepatitis: A, B, C                  | <input type="checkbox"/> Anxiety Disorder                     | <input type="checkbox"/> Cancer                  |
| <input type="checkbox"/> Heart Pacemaker   | <input type="checkbox"/> Eating Disorder               | <input type="checkbox"/> Frequent Headaches                  | <input type="checkbox"/> Psychiatric Treatment                | <input type="checkbox"/> Depression              |
| <input type="checkbox"/> Artificial Heart Valve  | <input type="checkbox"/> Glaucoma                      | <input type="checkbox"/> Artificial Joints (Hip, Knee, etc.) | <input type="checkbox"/> Sleep Apnea                          |  |
| <input type="checkbox"/> Diabetes, Type I <input type="checkbox"/> II <input type="checkbox"/> | <input type="checkbox"/> Chemotherapy for Cancer       |  | <input type="checkbox"/> Drug/Alcohol Addiction               | <input type="checkbox"/> Other _____             |

#### Sleep/Airway Issues

- |   |   |
|---|---|
| Do you tend to be a mouth-breather? <input type="checkbox"/> Yes <input type="checkbox"/> No            | Do you feel well-rested in the morning? <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| Are you often tired or sleepy during the day? <input type="checkbox"/> Yes <input type="checkbox"/> No  | Do you often snore at night? <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Do you awaken multiple times during the night? <input type="checkbox"/> Yes <input type="checkbox"/> No | Has anyone observed you stop breathing, gasping or struggling to breathe while asleep? <input type="checkbox"/> Yes <input type="checkbox"/> No |

### Are you allergic to or have you reacted adversely to any of the following?

*Please check any that apply.*

#### No Allergies

- |                                  |                                    |                                    |  |                                       |  |   |
|----------------------------------|------------------------------------|------------------------------------|--|---------------------------------------|--|---|
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Triazolam | <input type="checkbox"/> Valium    | <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Other Antibiotics | <input type="checkbox"/> Metals/Jewelry   |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Percodan  | <input type="checkbox"/> Sulfa     | <input type="checkbox"/> Penicillin    | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Latex             | <input type="checkbox"/> Local Anesthetic |
|                                  | <input type="checkbox"/> Tylenol   | <input type="checkbox"/> Ibuprofen |  |                                       |  | <input type="checkbox"/> Amoxicillin      |

*List any other allergies here:* \_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status or medications.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Doctor Signature** \_\_\_\_\_ **Date** \_\_\_\_\_