

PATIENT INFORMATION

Mr., Mrs., Dr., Ms., Miss Marital Status _____ E-mail Address _____ Date _____

First Name _____ Middle _____ Last _____

Nickname _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____ Birth Date _____

Social Security Number _____ Whom may we thank for this referral? _____

Employer _____ Occupation _____

Spouse's Name _____ Spouse's DOB _____ Spouse's SSN _____

Person responsible for account (if not patient) _____

Address _____ Phone _____

MEDICAL HISTORY

Your physician's name _____ Last visit _____

Are you being treated by a physician now? _____ If yes, for what condition? _____

Please note other medical professionals that you visit at least 1 time per year (Please check all that apply):

___ Family Physician ___ Gynecologist ___ Chiropractor ___ Other specialists

Any recent serious illness? _____

Are you taking any medication? _____ If yes, what? _____

(this includes over the counter drugs, prescription drugs and birth control pills)

If yes, why? _____

Are you allergic to any medications? _____ If yes, what? _____

Are you allergic to latex? Yes No

Are you in good health? _____

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Any History of:

Heart Problems (Pacemaker/Murmur)

If yes to above, has this been confirmed with an echocardiogram by a cardiologist?

Heart Valve Problems

High Blood Pressure

Rheumatic Fever

Kidney/Liver Disease

Glaucoma

Cancer

Emotional Stress/Depression

Prolonged Bleeding/Anemia

Asthma/Respiratory Problems

Eating Disorder

Epilepsy

Arthritis

Hepatitis

Diabetes

Acid Reflux

Osteoporosis

AIDS or HIV infection

Artificial Joints

WOMEN: Are you pregnant?

Are you nursing?

Medications/Explanation

Yes No _____

Yes No _____

Yes No _____

Yes No _____

Yes No _____

Yes No _____

Yes No _____

Yes No _____

Yes No _____

Yes No _____

Yes No _____

Yes No _____

Yes No _____

Yes No _____

Yes No _____

Yes No _____

Yes No _____

Yes No _____

Yes No _____

Yes No _____

Yes No _____

Yes No _____

DENTAL HISTORY

Have you had any serious trouble associated with any previous dental treatment? Yes No

If so, explain _____

Are you wearing removable dental appliances? Yes No

Do you have recurring mouth ulcers? Yes No

Do you have halitosis (bad breath)? Yes No

Chief Dental Complaint _____

Have your dental experiences been pleasant? Yes No

Have you ever worn braces? Yes No

Approximate date of orthodontic treatment? From: _____ To: _____

Would you consider that treatment successful? Yes No

How long did you consistently wear a retainer as part of your orthodontic treatment? No. of years _____

Are you currently experiencing any pain or discomfort of your mouth, gums or teeth? Yes No

Please describe the pain or discomfort you are experiencing _____

Have you experienced any pain or discomfort of your mouth, gums or teeth in the past? Yes No

Please describe any past issues involving your dental health _____

GETTING ACQUAINTED

Recent medical research indicates a strong correlation between daily habits and overall medical and dental health. Activity and stress levels can often contribute to existing conditions or can lay at the root of other health related concerns.

I consider my teeth/smile to be (please check all that apply):

___ Perfect ___ Slightly crooked ___ Very crooked ___ Discolored ___ Painful ___ Chipped
_____ Other

Have you set goals for your dental and periodontal health with a previous dentist? Yes No

Did you successfully complete the plan as outlined by you and your previous dentist? Yes No

Have you set goals with a previous dentist for the aesthetic or cosmetic improvement of your smile? Yes No

Did you successfully complete the treatment plan for these aesthetic or cosmetic improvements with your previous dentist? Yes No

I currently use these over the counter medications or treatments (Please check all that apply):

___ Whitening Strips ___ Whitening Toothpaste ___ Whitening Trays ___ Orajel ___ Sensitivity Toothpaste

___ Medication for canker or mouth sores How often do you experience mouth sores? _____

___ Night Guards/Grinding Guard ___ Pain relievers ___ Pain relievers especially designed for night usage

___ Icy Hot, Bengay other topical pain relievers for muscle pain relief including sleeves and other treated wraps or bandages

___ Antacids such as Roloids, Tums, Pepcid etc. ___ Calcium supplements _____ Other

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Parent _____