PATIENT HISTORY AND INFORMATION

Please Print Clearly & Legibly

PERSONAL & CONTACT INFORMATION

First Name____________________________ Last Name________________________________ Nickname____________________

Date of Birth (MM/DD/YYYY) _____/_____/_________ Age_____ Gender: M ❑ F ❑ Marital Status: Single ❑ Married ❑ Other

Spouse's First Name__________________________________ Spouse's Last Name (If different) ____________________________

Patient's Employer__________________________________ Patient's Occupation ____

Addresses:

Mailing or Home Address_________________________________ Apt #__________

City_________________________________ State__________ Zip_______________

Work Address___________________________ ________Ste./Building #__________

City_________________________________ State__________ Zip_______________

Phone Numbers:

Home Phone (____)____________

Work Phone (____)____________

Cell Phone (____)____________

Other Number (____)____________

Email Address: ____ Confirmation Via Email: Yes ❑ NO ❑

Emergency Contact Information:

Name _______________________________ Relationship___________________________________ Primary

Phone(_____)_____________________________ Secondary Phone Number(_____)_____________________________

DENTAL HISTORY

Reason for today's visit to our office____

General Dentist_________________________________City/State__________________________Phone (______)______________

Who may we thank for referring you to our office?____

Date of last dental appointment ______________ What was done?____

How long have you been a patient in your dentist's practice?__________________

How often do you have your teeth cleaned at the dentaloffice?_________________

How often do you; Brush per day? ___________ Floss per week? ______________

What types of toothbrushes? Soft Brush ❑ Hard Brush ❑ Electric ❑

	Yes	No	
Are you experiencing any discomfort in your mouth?-------	❑	❑	If Yes, Please Explain________________________________
Have you had previous gum treatment?-----------------------	❑	❑	If So, When?____
Do your gums bleed when you brush?------------------------	❑	❑	
Have you noticed any loose teeth or shifting?----------------	❑	❑	
Have you had complications following an extraction?-------	❑	❑	
Have you had gumboils or abscesses?------------------------	❑	❑	
Have you noticed any mouth odors or bad tastes?----------	❑	❑	
Are your teeth sensitive to heat, cold, chewing or sweets?	❑	❑	
Are you aware of grinding or clenching your teeth?---------	❑	❑	

MEDICAL HISTORY

	Yes	No	
Do you consider yourself in good health?--------	❑	❑	If No, Please explain____
Is a physician treating you now?-----------------	❑	❑	If so, what for?______________________________________

Name of Physician______________________________ City________________________ Phone (____)__________

Are you taking any drugs or medications? Please list:

____

Have you been hospitalized or had surgery within the last five years? If so, what for?________________________________

Check box "yes" or "no" if you have or had any of the following;

Yes	No		Yes	No	
❑	❑	Heart Problems, Angina, Heart Attack	❑	❑	Hepatitis, Liver disease, Jaundice
❑	❑	Rheumatic Fever, Heart Murmur	❑	❑	Kidney Disorder, Kidney Stones
❑	❑	Stroke	❑	❑	Respiratory Disorder, Asthma, Emphysema, Smoker
❑	❑	High Blood Pressure	❑	❑	Glandular or Thyroid Disorder
❑	❑	Bleeding Problems, Taking Blood Thinner	❑	❑	HIV, AIDS or Immune Disorder
❑	❑	Diabetes	❑	❑	Artificial Hips, Knees or Other Joints
❑	❑	Arthritis, Gout, Joint Problems	❑	❑	Depression, Anxiety, Panic Attacks
❑	❑	Epilepsy, Seizures	❑	❑	Tumor or Cancer
❑	❑	Ulcers, Stomach Problems, Reflux	❑	❑	Osteoporosis, Taken Fosamax

Do you have any other diseases or conditions not listed?-- ❑ ❑

If Yes, Pleaselist:____

Have you become sick from, shown an allergy to, or been told not to take the following?

Yes	No		Yes	No	
❑	❑	Local Anesthetics, Epinephrine	❑	❑	Latex
❑	❑	Penicillin, Amoxicillin	❑	❑	Codeine, Demerol, Vicodin or Valium
❑	❑	Tetracycline, Sulfas, Erythromycin	❑	❑	Aspirin, Ibuprofen, Tylenol, Aleve
❑	❑	Other Antibiotics			Other Medications Please list: ______________________________

	Yes	No
Have you had excessive bleeding requiring special treatment?----	❑	❑
Do injuries or cuts heal very slowly?----------------------------------	❑	❑
Have you had radiation treatment for a tumor?----------------------	❑	❑
Women: Are you pregnant or breast feeding?--------------------	❑	❑
Have you reached menopause?-------------------------	❑	❑

Patient/Parent Signature X ______________________________________ **Date** ______________

I certify that the above information is true and correct to the best of my knowledge.

Patient / Parent Signature X______________________________________**Date**__________

Date	Medical Changes **(FOR OFFICE USE ONLY)**	Initials