PATIENT INFORMATION

LEGAL NAME ______________________________
PREFERRED NAME ______________________________
GENDER ______________________________
HOME ADDRESS ______________________________
CITY ______________ ST______ ZIP____________
EMAIL ______________________________
EMPLOYER ______________________________

TODAY'S DATE ____________________
DATE OF BIRTH ____________________
HOME PHONE ____________________
CELL PHONE ____________________
BUSINESS PHONE ____________________
SOCIAL SECURITY # ____________________
DENTAL INSURANCE CO ____________________

PATIENT MEDICAL HISTORY

MEDICAL PHYSICIAN ______________________ OFFICE PHONE ______________________ DATE OF LAST MEDICAL EXAM ______________

NAME OF YOUR PHARMACY / LOCATION ______________________________ PHARMACY PHONE ______________________________

1. Are you under medical treatment now? Yes / No
2. Have you ever been hospitalized for any surgical operation or serious illness? Yes / No
3. Are you taking any medication(s) including non-prescription medicine? Yes / No
   If yes, what medication(s) are you taking?
   ____
   ____
   ____
4. Are you taking Coumadin? Yes / No
5. Are you taking Bisphosphinates? Yes / No
6. Do you wear contact lenses? Yes / No
7. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? Yes / No
8. I grant permission to obtain bloodwork if ever needed. Yes / No
9. WOMEN ONLY:
   a) Are you pregnant or think you may be pregnant? Yes / No
   b) Are you nursing? Yes / No
   c) Are you taking birth control pills? Yes / No

10. Are you allergic to or or have you had any reactions to the following? (Check all that apply)

- ☐ Local anesthetics (eg. novocaine)
- ☐ Aspirin
- ☐ Benzodiazepines
- ☐ Penicillin or other antibiotics
- ☐ Sedatives
- ☐ Other (write below) ______________ ______________
- ☐ Sulfa Drugs
- ☐ Iodine

11. Social History

Do you currently smoke? Yes / No
- How much? ______________________
- For how long? ______________________

Have you smoked in the past? Yes / No
- When did you quit? ______________________

Do you drink alcohol? Yes / No
- How much? ______________________
- How often? ______________________

Do you use addictive/recreational drugs? Yes / No
- How often? ______________________

12. Do you have or have you had any of the following?

Yes / No	Heart Attack	Yes / No	Leukemia	Yes / No	Asthma
Yes / No	Heart Disease	Yes / No	Cancer	Yes / No	Emphysema
Yes / No	Cardiac Pacemaker	Yes / No	Radiation Therapy	Yes / No	Easily Winded
Yes / No	Heart Murmur	Yes / No	Chemotherapy	Yes / No	Hay Fever / Allergies
Yes / No	Chest Pains / Angina	Yes / No	AIDS / HIV Infection	Yes / No	Tuberculosis
Yes / No	Mitral Valve Prolapse	Yes / No	Hepatitis (A, B, or C)	Yes / No	COPD
Yes / No	Low / High Blood Pressure	Yes / No	STDs	Yes / No	Sinus Problems
Yes / No	Rheumatic Fever	Yes / No	Kidney Disease	Yes / No	Sleep Apnea
Yes / No	Swollen Ankles	Yes / No	Thyroid Problems	Yes / No	Other Respiratory Problems
Yes / No	Fainting / Seizures	Yes / No	Frequently Tired	Yes / No	Joint Replacement / Implant
Yes / No	Epilepsy / Convulsions	Yes / No	Anemia	Yes / No	Stomach Troubles / Ulcers
Yes / No	Diabetes (Type I or II)	Yes / No	Arthritis	Yes / No	Anxiety / Depression
Yes / No	Stroke	Yes / No	Recent Weight Loss	Yes / No	Other ______________ ______________
Yes / No	Glaucoma	Yes / No	Liver Disease		

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PATIENT DENTAL HISTORY

Yes / No 1. Do your gums bleed while brushing or flossing?

Yes / No 2. Are your teeth sensitive to hot or cold liquids / foods?

Yes / No 3. Are your teeth sensitive to sweet or sour liquids / foods?

Yes / No 4. Do you feel pain in any of your teeth?

Yes / No 5. Do you have any sores or lumps in or near your mouth?

Yes / No 6. Have you had any head, neck, or jaw injuries?

7. Have you ever experienced any of the following problems in your jaw?

Yes / No a) Clicking
Yes / No b) Pain (joint, ear, side of face)
Yes / No c) Difficulty in opening or closing
Yes / No d) Difficulty in chewing

Yes / No 8. Do you have frequent headaches?

Yes / No 9. Do you clench or grind your teeth?

Yes / No 10. Do you bite your lips or cheeks frequently?

Yes / No 11. Have you ever had any difficult extractions in the past?

Yes / No 12. Have you ever had prolonged bleeding following extractions?

Yes / No 13. Have you ever had any orthodontic treatment?

Yes / No 14. Have you ever had periodontal scaling / root planing? If yes, please note the date ______________

Yes / No 15. Have you been on a regular dental cleaning schedule?
If yes, circle one: 6 Months I 4 Months I 3 Months

16. When was your last dental visit? ____

17. What is the name of your last dentist? ____

SIGNATURE

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X ____ ____

PATIENT, PARENT, OR GUARDIAN DATE