DATE _____

PATIENT'S NAME: MRS., MR., MISS, MS., DR., _____ BIRTH DATE _____ MARRIED ____ SINGLE ____

NAME OF SPOUSE _____

IF A CHILD, PARENT'S NAME _____

STREET ADDRESS _____ HOME PHONE _____ CELL PHONE _____

CITY _____ STATE _____ ZIP _____

PATIENT EMPLOYED BY _____ PHONE _____

OCCUPATION AND POSITION
(IF RETIRED, FROM WHAT OCCUPATION) _____ HOW LONG HELD _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE EMPLOYED BY _____ PHONE _____

IN CASE OF EMERGENCY, WHOM SHOULD BE NOTIFIED _____ PHONE _____

INSURANCE INFORMATION

DO YOU HAVE INSURANCE THAT MAY COVER ANY PART OF OUR PROFESSIONAL SERVICES YES _____ NO _____

IF SO, NAME OF COMPANY _____ POLICY NO. _____

(PLEASE PROVIDE CLAIM FORMS FOR ALL PROFESSIONAL SERVICES THAT MAY BE ELIGIBLE FOR INSURANCE COVERAGE)

SOCIAL SECURITY NUMBER _____

SPOUSE'S SOCIAL SECURITY NUMBER _____

WHOM MAY WE THANK FOR REFERRING YOU _____

DO YOU HAVE ANY HOBBIES OR SPECIAL INTERESTS _____

MEDICAL HISTORY

Please list last name and phone number of your general physician. _____

Please list all medications, including daily amounts, you are taking. _____

_____

Last physical examination/hospitalization _____

Do you take any of the following on a regular basis?

Aspirin	Yes ☐	No ☐	Coumadin	Yes ☐	No ☐	Garlic	Yes ☐	No ☐
St. John's Wort	Yes ☐	No ☐	Ginko Biloba	Yes ☐	No ☐	Vitamin E	Yes ☐	No ☐

Do you take blood thinners? Yes ☐ No ☐

Are you taking any medications for: Nerves (Tranquilizers) ☐, Thyroid ☐, Hormones ☐, Steroids ☐, Birth Control Pills ☐, Depression ☐
Diabetes (Pills or Shots) ☐, Epilepsy (Dilantin) ☐,

Are you allergic to: Penicillin ☐ Erythromycin ☐ Tetracycline ☐ Codeine ☐ Local Anesthetic/novocaine ☐ Costume Jewelry ☐

What other medications are you allergic to? _____

Have you ever been treated for:

Ulcers	Yes ☐	No ☐	Asthma or hay fever	Yes ☐	No ☐
Gastrointestinal Disease	Yes ☐	No ☐	Chronic Sinus Infection	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Chronic Cough	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐	Rheumatoid Arthritis	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Degenerative (Osteo) Arthritis	Yes ☐	No ☐
Congenital Heart Lesions	Yes ☐	No ☐	Joint or Hip Replacement	Yes ☐	No ☐
Heart disease	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Rheumatic fever	Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐
Mitral Valve Prolapse	Yes ☐	No ☐	Cancer or tumors	Yes ☐	No ☐
Abnormal Blood pressure	Yes ☐	No ☐	Venereal Disease	Yes ☐	No ☐
Heart murmur	Yes ☐	No ☐	H.I.V., A.I.D.S., or A.R.C.	Yes ☐	No ☐
Pacemaker	Yes ☐	No ☐	Drug Addiction	Yes ☐	No ☐
Kidney disorders	Yes ☐	No ☐	Chronic dry mouth	Yes ☐	No ☐
Physical Handicaps	Yes ☐	No ☐	Do you have any children younger than 13?	Yes ☐	No ☐
Tuberculosis or lung disease	Yes ☐	No ☐	Are you subject to prolonged bleeding	Yes ☐	No ☐
Jaundice or liver disease	Yes ☐	No ☐	Are you pregnant	Yes ☐	No ☐
Hepatitis	Yes ☐	No ☐	Do you smoke	Yes ☐	No ☐

DOCTORS USE ONLY PLEASE	

Thank you for choosing our office to care for your dental health. In order to care for you properly, we ask that you complete the following health history. Please ask the receptionist about our educational literature. Again, thank you for choosing our office.

How can we help you? _____

When was your last dental visit? _____

Have you ever had any serious problem associated with previous dental treatment? ..... Yes ☐ No ☐

If so explain _____

Do you avoid brushing any part of your mouth because of pain? ..... Yes ☐ No ☐

If yes, what part? _____

Do you feel twinges of pain when your teeth come in contact with (Circle) HOT COLD SWEET SOUR

Do you chew on only one side of your mouth? ..... Yes ☐ No ☐

If yes explain _____

On a scale of 1-10, 10 being the highest, what priority do you give your teeth? ..... _____

How often do you brush your teeth? _____

How often do you floss? _____

Do your gums bleed while brushing? ..... Yes ☐ No ☐

Do your gums bleed while flossing? ..... Yes ☐ No ☐

Does the floss tear or break when flossing any of your teeth? ..... Yes ☐ No ☐

Do you feel pain to any of your teeth when brushing or flossing them? ..... Yes ☐ No ☐

Do you have any pain in any part of your mouth or in any tooth while biting or chewing? ..... Yes ☐ No ☐

Do your gums feel tender or swollen? ..... Yes ☐ No ☐

Do you usually have many cavities? ..... Yes ☐ No ☐

Do you lose fillings or break fillings? ..... Yes ☐ No ☐

Do you gag easily? ..... Yes ☐ No ☐

Do you feel your bite is off; bad bite? ..... Yes ☐ No ☐

Does food catch between your teeth? ..... Yes ☐ No ☐

Do you eat a piece of candy or chocolate every day? ..... Yes ☐ No ☐

Do you drink regular soft drinks or chew regular gum every day? ..... Yes ☐ No ☐

Do you have a regular exercise program? ..... Yes ☐ No ☐

Are you happy with your past dentistry? ..... Yes ☐ No ☐

Are you familiar with the term "preventive dentistry"? ..... Yes ☐ No ☐

Can you chew properly? ..... Yes ☐ No ☐

Are you happy with the appearance of your teeth? ..... Yes ☐ No ☐

Have you ever had problems with your TMJ? ..... Yes ☐ No ☐

Are you in the habit of biting your nails or any other hard object? ..... Yes ☐ No ☐

Do your jaws ever feel tired when you wake up, talk, or chew a lot? ..... Yes ☐ No ☐

Do you ever have pain, clicking, popping, or grating sounds from your jaw joint? ..... Yes ☐ No ☐

Does it hurt when you open wide or take a big bite? ..... Yes ☐ No ☐

Does your jaw ever lock or go out, i.e. get stuck open or closed? ..... Yes ☐ No ☐

Does your jaw make noise so that it bothers you or others? ..... Yes ☐ No ☐

Do you ever have ringing or pain in your ears? ..... Yes ☐ No ☐

Do you have chronic earaches? ..... Yes ☐ No ☐

Do you grind your teeth during the day or night? ..... Yes ☐ No ☐

Have you ever had orthodontics (braces)? ..... Yes ☐ No ☐

Have you ever had periodontal therapy (gum surgery)? ..... Yes ☐ No ☐

Have you ever had endodontic therapy (root canal)? ..... Yes ☐ No ☐

Have you ever been treated by an oral surgeon? ..... Yes ☐ No ☐

What is the one thing that you liked least about any former dentist or the office? _____

What is the one thing that you liked best about any former dentist or the office? _____

IF THERE IS A NEED TO CANCEL AN APPOINTMENT, PLEASE GIVE US 48-HOURS NOTICE SO ANOTHER PATIENT MAY RECEIVE CARE.

THIS INFORMATION WAS GIVEN BY: _____ _____

Dental History

These things are important to me about my dental health:

Former Dentist's Name:_____ City/State:_____

PLEASE CIRCLE ONE:

1. My mouth is:
   a. very comfortable.
   b. moderately comfortable.
   c. uncomfortable.
2. I:
   a. think the appearance of my mouth is excellent.
   b. think the appearance of my mouth is adequate.
   c. wish I could change the appearance of my mouth.
3. I:
   a. want to save my teeth at all costs.
   b. prefer to keep my teeth if cost and time are reasonable.
   c. expect to someday lose my teeth and have dentures.
4. I:
   a. have set goals to achieve optimum oral health with a previous dentist.
   b. want to set goals to achieve optimum oral health.
   c. not very interested in setting personal goals to achieve optimum oral health.
5. I:
   a. have followed the recommendations for optimum dental health given by my dentist.
   b. have not done what dentists have recommended I do with my mouth.
   c. usually only go to the dentist for emergencies.
6. I think I:
   a. am in EXCELLENT oral health.
   b. am in GOOD oral health.
   c. am in POOR oral health.
7. I desire:
   a. excellent oral health.
   b. average or good oral health.
   c. crisis care only.

8. What are some questions about dentistry and your oral health that you have never had adequately answered?_____
   _____
   _____

Signature_____ Date_____

Thank you!