PATIENT INFORMATION

LAST NAME, FIRST NAME | BIRTHDATE | SOCIAL SECURITY # | PARTNER'S NAME

MAILING ADDRESS | CITY | ZIP CODE

EMAIL ADDRESS:

HOW WOULD YOU PREFER TO RECEIVE COORESPONDENCE FROM OUR OFFICE? _____ MAIL _____ EMAIL

HOME PHONE # | CELL PHONE # | WORK PHONE #

WHICH NUMBER WOULD YOU PREFER US TO CONTACT YOU WITH? ____ HOME ____ CELL ____ WORK

HOW DID YOU HEAR ABOUT US? ___ FRIEND, IF SO, WHO_____

___ ADVERTISEMENTS; IF SO, WHICH ONE: ___ PHONE BOOK ___ INTERNET___ WALKED BY___OTHER

EMPLOYER | DENTAL INS. COMPANY | EMPLOYEE ID# & BIRTHDATE | GROUP/ POLICY#

MEDICAL INFORMATION

PHYSICIAN NAME | ADDRESS | PHONE# | CONTACT IN CASE OF EMERGENCY

WHEN WAS YOUR LAST MEDICAL EXAM? _____ DO YOU SMOKE? IF SO, HOW OFTEN?_____

HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE LAST YEAR? _____

HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS WITHIN THE LAST 5 YRS? _____

ARE YOU TAKING FOSAMAX MEDICATION? _____ ARE YOU TAKING BLOOD THINNER MEDICATION? _____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING: _____

_____

_____

DO YOU HAVE INSTRUCTIONS FROM A PHYSICIAN TO TAKE PRE-MEDICATION FOR DENTAL WORK? _____

DO YOU HAVE A HISTORY OF COLD SORES OR FEVER BLISTERS? ____ YES ____ NO

DO YOU BLEED/BRUISE EXCESSIVELY? ____ YES ____ NO

HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS?

___ HEART DISEASE	___ CANCER/TUMOR	___ INFLAMMATORY RHEUMATISM
___ HEART MURMUR	___ KIDNEY TROUBLE	___ HIGH BLOOD PRESSURE
___ RHEUMATIC FEVER	___ ARTHRITIS	___ LOW BLOOD PRESSURE
___ ARTIFICIAL HEART VALVE	___ VENEREAL DISEASE	___ HEPATITIS/LIVER DISEASE
___ ARTIFICIAL JOINTS	___ DIABETES	___ CIRCULATORY DISEASE
___ TESTED HIV POSITIVE	___ AIDS	___ FAINTING SPELLS/SEIZURES
___ THYROID DISEASE	___ TUBERCULOSIS	___ STOMACH ULCERS
___ BRUISE EASILY	___ SINUS TROUBLE	___ ASTHMA/ HAY FEVER

(WOMEN) ARE YOU PREGNANT? IF SO, WHAT TRIMESTER ARE YOU IN? _____

HAVE YOU EVER HAD ANY UNUSUAL REACTION TO THE FOLLOWING?

___ ASPIRIN ___ SEDATIVES ___ CODEINE ___ PENICILLIN
___ ANESTHETICS ___ NITROUS OXIDE ___ ERYTHROMYCIN ___ VALIUM
___ AMOXICILLIN ___ IODINE ___ SULFA

___ OTHER MEDICATIONS_____

DO YOU REGULARLY TAKE DIETARY SUPPLEMENTS OR HERBAL MEDICINES?_____ YES ____ NO
IF YES, DO YOU REGULARY TAKE ANY OF THE FOLLOWING:

___ DIET OR ENERGY SUPPLEMENTS ___ ECHINACEA ___ GARLIC
___ GINGER ___ GINKO ___ GINSENG
___ KAVA ___ ST JOHN'S WART ___ VALERIAN
___ VITAMIN E.400I.U. ___ FISH OIL> 3 Grams /day ___ Other _____

DENTAL INFORMATION

WHEN WAS YOUR LAST DENTAL EXAM/CLEANING? _____

ARE YOU CURRENTLY EXPERIENCING ANY PAIN? _____

HAVE YOU HAD ANY PERIODONTAL (GUM) TREATMENTS? ____ YES ____ NO ____ DON'T KNOW

HAVE YOU HAD ORTHODONTIC (BRACES) TREATMENT? ____ YES ____ NO ____ DON'T KNOW

HAVE YOU EVER HAD A BITE EQUILIBRATION (ADJUSTMENT) ____ YES ____ NO ____ DON'T KNOW

DO YOUR GUMS BLEED WHEN YOU BRUSH OR FLOSS? ____YES ____ NO _____ DON'T KNOW

DO YOU HAVE CLICKING, POPPING OR DISCOMFORT IN THE JAW? ____ YES ____ NO ____ DON'T KNOW

DO YOU HAVE ANY EARACHES, HEADACHES, OR NECK PAIN? ____ YES ____ NO ____ DON'T KNOW

DO YOU BRUX OR GRIND YOUR TEETH? ____ YES ____ NO ____ DON'T KNOW

IS YOUR MOUTH DRY? ___ YES ___ NO ___ DON'T KNOW

ARE YOUR TEETH SESITIVE TO: ____ COLD ____ HOT ____ SWEETS ____ PRESSURE

HAVE YOU EVER HAD ANY PROBLEMS ASSOCIATED
WITH PREVIOUS DENTAL TREATMENT? ____ YES __ __ NO ___ DON'T KNOW

HOW DO YOU FEEL ABOUT YOUR SMILE? _____

SIGNATURE DATE

ADDITIONAL NOTES OR CONCERNS: