NAME_____ DATE_____
Last (please print) First Middle

ADDRESS_____
Number and Street City State Zip

TELEPHONE Home_____ Work_____ Mobile_____

OCCUPATION_____ EMPLOYED BY_____

BUSINESS ADDRESS_____

DATE OF BIRTH_____ AGE_____ GENDER_____ HEIGHT_____ WEIGHT_____

SINGLE_____ MARRIED_____ DIVORCED_____ NAME OF SPOUSE_____

DRIVERS LICENSE #_____ SOCIAL SECURITY #_____

GUARDIAN RESPONSIBLE FOR PATIENT_____ PHONE #_____

IF YOU ARE COMPLETING THIS FORM FOR ANOTHER PERSON, WHAT IS YOUR REALTIONSHIP TO THAT PERSON?_____

PHYSICIAN:_____ PHONE #_____

DENTIST:_____

REFERRED BY:_____

PERSON RESPONSIBLE FOR PAYMENT_____

METHOD OF PAYMENT: CASH_____ CHECK_____ VISA/MC_____ DENTAL INSURANCE_____

NAME OF INSURANCE CO._____

GROUP #_____POLICY HOLDER_____

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Your answers are for our records ONLY and will be considered Personal and Confidential. Please check the answer to EVERY question, YES OR NO.

DENTAL HISTORY

Yes___ No___ 1. Do you clench or grind your teeth?
Yes___ No___ 2. Do you have any pain in your jaw joints?
Yes___ No___ 3. Do you receive regular dental care?
4. When was your last dental visit?_____
Yes___ No___ 5. Have you had any teeth extracted?
Yes___ No___ 6. Were there any complications?
Yes___ No___ 7. Do you have pain in your teeth or gums?
Yes___ No___ 8. Do your gums bleed when you brush?
Yes___ No___ 9. Do your gums feel tender or swollen?
Yes___ No___ 10. Do you have any loose teeth?
Yes___ No___ 11. Do you have bad breath or a bad taste?
Yes___ No___ 12. Do you like the way your teeth look?
Yes___ No___ 13. Are you nervous about coming to the Dentist?
Yes___ No___ 14. Have you had any unpleasant dental experiences?
Yes___ No___ 15. Have you had an allergic reaction to any medication?
Yes___ No___ 16. Have you had previous periodontal treatment?
If yes, when?_____
Yes___ No___ 17. Do you have dental implants?
Yes___ No___ 18. Do you smoke? If yes, how much?_____
How many years?_____
Yes___ No___ 19. Do you chew tobacco? If yes, for how long?_____
Yes___ No___ 20. Have you had orthodontics (braces)? If yes, when?_____

PLEASE ANSWER MEDICAL HISTORY ON REVERSE SIDE

MEDICAL HISTORY

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Allergies: Drugs/medicines you take:

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Yes___ No___ 1. Are you in good health? If no, explain_____

Yes___ No___ 2. Has there been any change in your general health within the past year? If yes, what?_____

3. Date of last physical exam_____

Yes___ No___ 4. Are you under the care of a physician?

Yes___ No___ 5. Have you had any serious illness, operation or accident?

Yes___ No___ 6. Have you been HOSPITALIZED or had a serious illness within the past FIVE (5) YEARS?

7. Do you have or have you ever had any of the following:

Cancer? If yes, when?_____ What type?_____ Treatment? Surgery Radiation Chemotherapy

JOINTS REPLACED: HIP_____ KNEE_____SHOULDER_____OTHER_____

MITRAL VALVE PROLAPSE____DAMAGED OR ARTIFICIAL HEART VALVES____CONGENITAL HEART DISEASE_____

CARDIAC PACEMAKER_____DEFRIBILLATOR_____HEART TROUBLE_____HEART ATTACK_____ANGINA_____

HIGH BLOOD PRESSURE_____ ARTERIOSCLEROSIS_____STROKE_____HEART MURMUR_____

RHEUMATIC HEART DISEASE_____IRREGULAR HEART BEAT_____

Yes___ No___ 8. Do you have pain in your chest upon exertion?

Yes___ No___ 9. Are you ever short of breath after mild exercise?

Yes___ No___10. Have you ever taken Redux or Fen Phen?

DO YOU HAVE OR HAVE YOU EVER BEEN TOLD YOU HAVE ANY OF THE FOLLOWING:

Yes___ No___11. Rheumatic Fever?

Yes___ No___12. Sleep Apnea?

Yes___ No___13. Alcoholism?

Yes___ No___14. Drug Addiction?

Yes___ No___15. Allergies?

Yes___ No___16. Sinus trouble?

Yes___ No___17. Asthma, Emphysema or Hay Fever?

Yes___ No___18. Hives or Skin rash?

Yes___ No___19. Fainting spells, Epilepsy or Seizures?

Yes___ No___20. Diabetes?

Yes___ No___21. Hepatitis, Jaundice or Liver Disease?

Yes___ No___22. Arthritis?

Yes___ No___23. Inflammatory Rheumatism (Painful swollen joints)?

Yes___ No___24. Stomach Ulcers?

Yes___ No___25. Kidney trouble?

Yes___ No___26. Tuberculosis?

Yes___ No___27. Chronic Bronchitis?

Yes___ No___28. Sickle Cell Anemia or Disease?

Yes___ No___29. Blood disorder such as anemia or leukemia?

Yes___ No___30. Neck or Back pain?

Yes___ No___31. Sexually Transmitted Disease?

Yes___ No___32. Eye trouble; Glaucoma or Cataracts?

Yes___ No___33. Skin rashes or bruises?

Yes___ No___34. Cold Sores or Herpes?

Yes___ No___35. AIDS or ARC?

Yes___ No___36. Have you been tested for HIV?

Yes___ No___37. Do you have a cough or cough up blood?

Yes___ No___38. Have you had abnormal bleeding following extractions, surgery or trauma?

Yes___ No___39. Do you bruise easily?

Yes___ No___40. Have you ever required a blood transfusion?

Yes___ No___41. Have you had surgery or radiation treatment for a tumor, growth or other condition of your head or neck?

Yes___ No___42. ARE YOU TAKING ANY PILLS, TABLETS, DRUGS OR MEDICATION?

43. Are you taking any of the following?

Yes___ No___ Antibiotic or sulfa drugs?

Yes___ No___ Anticoagulants (blood thinners)?

Yes___ No___ Medicine for high blood pressure?

Yes___ No___ Cortisone (steroids)?

Yes___ No___ Tranquilizers or Anti-Depressants?

Yes___ No___ Antihistamines?

Yes___ No___ Arthritis Medication?

Yes___ No___ Aspirin?

Yes___ No___ Insulin, Tolbutimide, (Orinase) or similar drug?

Yes___ No___ Digitalis or drugs for heart trouble?

Yes___ No___ Nitroglycerin?

Yes___ No___ Cholesterol lowering drug?

Yes___ No___ Pain medicines?

*Other_____

44. Are you allergic or have you had a reaction to:

Yes___ No___ Local anesthetics?

Yes___ No___ Penicillin or other antibiotics?

Yes___ No___ Barbiturates, sedatives or sleeping pills?

Yes___ No___ Aspirin?

Yes___ No___ Codeine?

Yes___ No___ *Other Narcotics_____

_____

Yes___ No___45. Do you have any disease, condition or problem not listed above that you think we should know about?

If YES, explain:_____

_____

Yes___ No___46. Are you wearing contact lenses?

Yes___ No___47. Have you been under the care of a psychiatrist or psychologist within the past five (5) years?

Yes___ No___48. WOMEN: Are you pregnant?

This is to verify that the medical and dental history I have given is correct to the best of my knowledge.

Signature_____ Relation to Patient_____