WELCOME

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Date: / /

Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name: Last Name: Middle Initial:

Preferred Name:

Patient's Address:

City: State: Zip:

Home Phone: ( ) Work Phone: ( ) Cell Phone: ( )

☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Date of Birth: / / Age Soc. Sec. No.: Driver Lic. No.:

Email: ☐ I would like to receive communication by email

Employed by / Retired from: Position

Emergency Contact: Phone: ( ) Relationship:

Preferred Pharmacy: Location:

Is there someone we can thank for referring you to our office?

RESPONSIBLE PARTY (if other than patient)

Name:

Address:

City: State: Zip: Phone(s):

Date of Birth: / / Soc. Sec. No.: Relationship to Patient:

DENTAL INSURANCE INFORMATION (Please also present card to receptionist)

☐ I am covered by dental insurance, **with information as follows:** ☐ I am not covered by dental insurance **(go to next page)**

Policy Holder Name: Relationship to Patient:

Policy Holder Date of Birth: / / Policy Holder Soc. Sec. No.:

Policy Holder Address:_

City: State: Zip: Phone: ( )

If card is not presented, please provide the above information plus the following:

Policy Holder ID #: Group No.:

Employer/Source of Insurance: Employer Phone:

Dental Insurance Company Name:

Dental Ins. Co. Address & Phone:

DENTAL HISTORY

When was your last dental visit? / / Where:

Reason for that visit:

Are you uncomfortable at this time? ☐ Yes ☐ No

Level of Pain (circle one)

1 2 3 4 5 6 7 8 9 10

mildly bothersome worst pain of my life

Is the pain ☐ Episodic or ☐ Constant?

Is the pain brought on by: ☐ Cold ☐ Heat ☐ Biting pressure ☐ While eating ☐ Sweets

Have you noticed your bite changing? ☐ Yes ☐ No

Are you aware of clenching or grinding? ☐ Yes ☐ No

Do you have headaches/sore jaws? ☐ Yes ☐ No

Where? ☐ Temples ☐ Back of head ☐ Eyes/Sinuses ☐ Jaws

Do your gums bleed? ☐ Yes ☐ No

Does your food pack between your teeth? ☐ Yes ☐ No

Do you have mouth sores? ☐ Yes ☐ No

Are you happy with your smile? ☐ Yes ☐ No

If not, what would you change? ☐ Color ☐ Shape ☐ Spacing ☐ Other

Please tell us what you do to take care of your mouth:

HEALTH HISTORY, PART 1

Last physical exam / /

Patient's Physicians

Primary Care:

Specialist(s):

Findings:

Are you being treated by a physician now? ☐ Yes ☐ No

Any recent serious illness? ☐ Yes ☐ No

Have you been hospitalized recently? ☐ Yes ☐ No

HEALTH HISTORY, PART 2

Medications

Prescription Medications	Amount	#/Day

Known Allergies:

Do you use:

Tobacco?	☐ Yes	☐ No	How much?
Alcohol?	☐ Yes	☐ No	How much?
Other habitual substances?	☐ Yes	☐ No	How much?

Do you have a history of:	Yes	No
Heart problems	☐	☐
Heart valve replacement	☐	☐
Pacemaker	☐	☐
Angina or chest pain	☐	☐
Heart murmur	☐	☐
Rheumatic fever	☐	☐
Swelling in ankles	☐	☐
Arteriosclerosis	☐	☐
Bleeding or clotting disorder	☐	☐
High blood pressure	☐	☐
Stroke	☐	☐
Tuberculosis	☐	☐
Shortness of breath	☐	☐
Persistent cough	☐	☐
Asthma	☐	☐
Seasonal allergies	☐	☐
Emphysema/COPD	☐	☐
Sleep apnea	☐	☐
Do you snore?	☐	☐
Ear, nose, throat problems	☐	☐
Type I diabetes	☐	☐
Type II diabetes	☐	☐
Other endocrine disease	☐	☐
Thyroid disease	☐	☐
Hepatitis	☐	☐
Liver disease	☐	☐

	Yes	No
Kidney disease	☐	☐
Genital/Urinary tract problems	☐	☐
Sexually transmitted disease	☐	☐
Positive HIV test/AIDS	☐	☐
Stomach/Intestinal problems	☐	☐
Other digestive problems	☐	☐
GERD	☐	☐
Rheumatoid arthritis	☐	☐
Other autoimmune disease	☐	☐
Skin diseases	☐	☐
Glaucoma/Eye problems	☐	☐
Osteoarthritis	☐	☐
Osteoporosis	☐	☐
Osteopenia	☐	☐
Have you ever taken bone-sparing drugs?	☐	☐
Prosthetic joint	☐	☐
Serious head/neck injury	☐	☐
Epilepsy/Seizures	☐	☐
Fainting/Dizziness	☐	☐
Frequent headaches	☐	☐
Emotional stress	☐	☐
Depression	☐	☐
Psychotherapy	☐	☐
Other mental illness	☐	☐

	Yes	No
Cancer	☐	☐
Type of Cancer:		
Chemo?	☐	☐
Radiation?	☐	☐
Other therapy?	☐	☐

Males:

Prostate trouble	☐	☐

Females:

Are you pregnant?	☐	☐
Breastfeeding?	☐	☐
Post-menopause?	☐	☐
Hormone replacement therapy?	☐	☐

Other conditions not listed:

Signature **Date**