PATIENT INFORMATON

Name: _____ Date: _____ SS #: _____
Employer: _____ Spouse's Employer: _____
Occupation: _____ Spouse's Occupation: _____
Patient email: _____ Birthdate: _____ Marital Status: _____
Name you would prefer that we call you: _____
Mailing address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Do you have Dental Insurance? _____
Business Phone: _____ Policy Holder: _____
Mobile Phone: _____ Dental Insurance Company: _____
Mobile Phone Carrier: _____ Employer of Policy Holder: _____
Your Dentist: _____ Policy Holder DOB: _____ SS #: _____
Your Physician: _____ Reason for referral: _____
Referred by: _____ _____

DENTAL HISTORY

Last dental visit: _____ What was done at that time? _____
Last cleaning: _____ Do you go for regular visits? _____
Have you ever been treated for periodontal disease? _____ if so, when? _____
Do you experience pain from your gums or teeth? _____ Do your gums bleed? _____
How often do you brush your teeth? _____ Do you have a bad taste in your mouth? _____
Do you use dental floss? _____ Water Pick? _____ Proxa brush? _____
Are your teeth sensitive? _____ Too Sweets? _____ Too Hot? _____ Too Cold? _____
If teeth have been extracted, were replacements discussed? _____
Do you grind or clench your teeth? _____ Do you awaken with headaches? ☐ Yes ☐ No
How do you feel about your teeth in general and are you pleased with the appearance of your teeth? _____
_____
How do you feel about dentures or removable teeth? _____
Are you nervous about dental treatment? _____

MEDICAL HISTORY

Date of last physical exam: _____ Are you presently under a physician's care? _____
If yes, for what condition? _____

Do you have, or have you had any of the following? If so, please check it and provide a history.

☐ Hepatitis ☐ Jaundice ☐ Liver disease _____ ☐ Joint replacement _____
☐ Aids: HIV Positive _____ ☐ Stomach ulcers ☐ Duodenal Ulcers _____
☐ Rheumatic fever, Heart murmur _____ ☐ Kidney disease; ☐ Kidney infection _____
☐ Heart trouble ☐ Stroke ☐ Mitral valve prolapse _____ ☐ Cancer _____
☐ High blood pressure ☐ Low blood pressure _____ ☐ Glaucoma ☐ Prostate problems _____
☐ Diabetes ☐ Family history of diabetes _____ ☐ Abnormal bleeding: Blood disorders _____
☐ Asthma ☐ Hay fever ☐ Sinus problems _____ ☐ Anemia ☐ Clotting problems _____
☐ Epilepsy ☐ Seizures _____ ☐ Problems with previous extractions? _____
☐ Drug dependency ☐ Alcohol dependency _____ ☐ Are you pregnant? _____
☐ Arthritis ☐ Rheumatism _____ ☐ Do you smoke? How much? _____
Drug allergies or reactions– if yes, please specify _____
Do you take any drugs or medication? If yes, please list: _____
_____
Have you ever been told you need to take antibiotics before dental treatment? _____
_____
Recent hospitalizations? _____ Have you ever received blood? _____
Have you been treated for osteoporosis? _____ What medicine; when and how long did you take it? _____
_____
Do you regularly take dietary supplements or herbal medicines? ☐ Yes ☐ No
Please list: _____
_____

I certify that all of the information above is correct _____
Signature

BP _____ Summary: _____
_____
_____