Patient Information

Date _____

Full Name _____ Birth Date _____ Marital Status _____
Home Address _____ Zip _____ Home Phone _____
E-Mail _____ Cell Phone _____
Occupation _____ Employer _____ Social Security No. _____
Business Address _____ Zip _____ Work Phone _____
Name of Spouse _____ Occupation _____ Employer _____
Dental Insurance Company _____ Policy No. _____
Referred By _____ Previous Dentist _____
Name of Physician _____ Phone No. _____
In Case of Emergency Contact _____ Phone No. _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	Yes	No
1. Have you ever been hospitalized, major operations or serious illness? If so, what? _____	☐	☐
2. Are you under any medical treatment now?	☐	☐
3. Have you ever taken Fen-Phen/Redux?	☐	☐
4. Have you had any allergic reactions to any drugs including penicillin, codeine, novocaine, aspirin?	☐	☐
5. Has there been a change in your health in the past year?	☐	☐
6. Have you ever had a blood transfusion?	☐	☐
7. Have you ever had kidney dialysis treatment?	☐	☐
8. Have you ever had abnormal bleeding problems after a cut or tooth extraction?	☐	☐
9. Are you now taking drugs or medications? If so, what? _____		

10. Has a physician ever informed you that you had:

	Yes	No		Yes	No
Heart Ailment	☐	☐	Hepatitis or Yellow Jaundice	☐	☐
High Blood Pressure	☐	☐	Liver Disease	☐	☐
Rheumatic Fever	☐	☐	Venereal Disease	☐	☐
Heart Murmur	☐	☐	AIDS	☐	☐
Mitral Valve Prolapse	☐	☐	Stomach or Intestinal Disease	☐	☐
Angina	☐	☐	Kidney Disease	☐	☐
Stroke	☐	☐	Tumors or Growths	☐	☐
Blood Disease	☐	☐	Diabetes	☐	☐
Hemophilia	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Respiratory Disease	☐	☐
			Epilepsy	☐	☐

11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
12. Women: A. Are you pregnant?	☐	☐
B. Estimated Date of Delivery _____		

Signature _____ Date _____

Updating _____

_____

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_____

Medical History Summary

Blood Pressure:

Dental History

	Yes	No
1. Please state briefly the reason for your visit. _____		
2. Do you have discomfort in your mouth now?	☐	☐
3. How long since your last dental visit? _____		
4. Were X-rays taken of all teeth at that time?	☐	☐
5. Do your gums bleed, feel tender or irritated?	☐	☐
6. Are your teeth sensitive to hot/cold/sweets?	☐	☐
7. Does food wedge between certain teeth?	☐	☐
8. Are any teeth loose?	☐	☐
9. Do you grind, clench or grit your teeth?	☐	☐
10. Does your jaw ever click or cause pain opening or closing?	☐	☐
11. Have your front teeth separated creating spaces in them recently?	☐	☐
12. Have you ever had any teeth extracted?	☐	☐
If yes, have they been replaced to prevent shifting and tipping of remaining teeth and bite collapse?	☐	☐
13. Did you ever wear braces?	☐	☐
14. Have you ever worn any dental appliances?	☐	☐
15. Have you ever had a root canal?	☐	☐
16. Have you ever had gum treatments?	☐	☐
17. Do you wear dentures or plates?	☐	☐
If yes, are you satisfied with your present dentures?	☐	☐
18. Have you experienced any growths or sore spots in your mouth?	☐	☐
19. Do you have an unpleasant taste in your mouth?	☐	☐
20. Do you floss your teeth?	☐	☐

21. Type of tooth brush _____ hard or soft (circle one)

Updating _____

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Dental History Summary