Patient Information

PATIENT NAME: _____TODAY'S DATE_____

HOME ADDRESS: _____CITY_____STATE____ZIP_____

EMAIL ADDRESS_____HOME PH_____MOBILE_____

PREFERRED METHOD OF APPOINTMENT CONFIRMATION: EMAIL TEXT PHONE (CIRCLE ALL THAT APPLY)

SSN: _____ D/L #: _____ DOB: _____

MARITAL STATUS: _____

OCCUPATION: _____ EMPLOYER NAME: _____

BUSINESS ADDRESS: _____CITY: _____PHONE:_____

SPOUSE'S NAME: _____ SSN: _____PHONE:_____

SPOUSE'S OCCUPATION: _____EMPLOYER:_____

PERSON TO CONTACT IN AN EMERGENCY:

NAME: _____RELATION: _____

PHONE NUMBER: _____

PARTY RESPONSIBLE FOR PAYMENT OF ACCOUNT: _____

PHONE NUMBER: _____

WHOME MAY WE THANK FOR REFERRING YOU? _____

REASON FOR THIS VISIT? _____

HEALTH HISTORY

For your safety and to assist us in accurately diagnosing and treating you, please review this form completely and fill out all areas which pertain to you.

ALL INFORMATION IS PRIVATE AND CONFIDENTIAL

- **DENTAL HISTORY**

Your Previous Dentist: _____ City: _____ how long were you a patient? _____ Date of Last visit _____ Date of last cleaning _____Last x-rays_____

Check any of the following that you currently have or have had:

__Mouth Discomfort __Grind or Clench your teeth __Immediate relatives with loss of teeth
__Previous Periodontal Treatment __Clicking, Popping or pain in jaw __Gum Abscesses
__Orthodontic Treatment __Bad Dental Experience __Fear of dental Treatment
__Wake with Sore Jaw __Mouth Odor or Bad Taste __Cold sore or Fever Blisters
__Other Oral Lesions __Sensitive Teeth (hot, cold, sweets) __Gums Bleed when Brushing
__Loose or Shifting Teeth __Trouble in Chewing or Speaking __Bruise Easily
__Complications with or Following Previous Dental or Oral Surgical Treatment

- **MEDICAL HEALTH HISTORY**

1. How would you describe your current health? Excellent Good Fair Poor
2. Please list your current physicians
   (a) _____ Type_____ How long_____
   (b) _____ Type_____ How long_____
3. Date of last complete physical exam _____ Purpose _____
   Findings _____

	Circle "YES" or "NO"	Explain
1. Are you aware of any changes in your general health in the last year?	No Yes	_____
2. Have you been hospitalized for illness or surgery in the last 2 years?	No Yes	_____
3. Have you been under the care of a physician in the last 2 years?	No Yes	_____
4. Have you ever had excessive bleeding that required treatment?	No Yes	_____
5. Is there any history of diabetes in your family?	No Yes	_____
6. Are you required to restrict your activity in any way?	No Yes	_____
7. Are you on a special or restricted diet of any kind?	No Yes	_____
8. Do you smoke? No Yes How much? _____ How Long? _____		
9. Do you use smokeless tobacco? No Yes How Much? _____How Long? _____		
10. Do you snore?	No Yes	_____
11. When you wake in the morning, do you feel rested?	No Yes	_____
12. Do you fatigue easily as the day progresses?	No Yes	_____
13. What is your neck size?	Inches	_____

14. List any medications you are currently taking, please include any over the counter. _____
    _____
    _____

Please circle any of the following you are allergic to

Penicillin	Vibramycin	Novacaine	Tylenol	Codeine	Other _____
Erythromycin	Sulfa Drugs	Carbocaine	Aspirin	Ibuprofen	_____
Tetracycline	Keflex	Xylocaine	Anesthetics	Latex	_____

- **Indicate which of the following you currently have or have had. You must circle each response individually "YES" or "NO"**

Heart Trouble……NO YES
Heart attack or disease ……..NO YES
Angina……..NO YES
High Blood Pressure……NO YES
Low Blood Pressure……NO YES
Heart Murmur……NO YES
Rheumatic Fever……NO YES
Congenital Heart Lesions……NO YES
Artificial Heart Valve……NO YES
Scarlet Fever……NO YES
Heart Pacemaker……NO YES
Heart Surgery……NO YES
Shortness of Breath upon Mild Exertion……NO YES
Require more than 2 pillows to sleep……NO YES
Ankles Swell…… .NO YES
Epilepsy or Seizures…….. NO YES
Frequent Headaches……NO YES
Fainting or Dizzy Spells……NO YES
Cancer or Tumors……NO YES
Radiation Treatment……NO YES
Chemotherapy……NO YES
Arthritis/ Rheumatism……NO YES
Glaucoma……NO YES
Contact Lenses……NO YES
Hepatitis……NO YES
Liver Disease……NO YES

Anemia……NO YES
Artificial Joint……NO YES
Kidney, Bladder Trouble……NO YES
Thyroid Disease……NO YES
Emphysema……NO YES
Persistent Cough……NO YES
Tuberculosis……NO YES
Asthma……NO YES
Hay Fever……NO YES
Sinus Trouble……NO YES
Allergies or Hives……NO YES
Diabetes……NO YES
Frequent Thirst
and/or Urination……NO YES
Stroke……NO YES
Jaundice……NO YES
A.I.D.S……NO YES
Blood Transfusions……NO YES
Drug or Alcohol Addiction……NO YES
Hemophilia……NO YES
Ulcers……NO YES
Bisphosphonate Treatment……NO YES
Psychiatric Care……NO YES
Unintentional Weight loss or gain……NO YES
Are you a Nervous Person……NO YES

To the best of my knowledge, all of the preceding answers are correct and true. If I ever have any changes in my health or if my medications change, I will inform the doctor on or before my next appointment without fail.

Patient Signature **DATE**

Clinician Signature **DATE**