DENTAL HISTORY:

PATIENT NAME: _____ **DOB:** _____

- If needed, can we contact your previous dentist for your dental records? Y/N
  If Yes, what's the dentist's name and phone number? _____
  _____
- Do your gums bleed when you brush or floss? Y/N
- Are your teeth sensitive to: (Please circle)
  Cold Hot Sweets Pressure
- Does food or floss get caught between your teeth? Y/N
- Do you experience dry mouth? Y/N
- Have you ever had periodontal (gum) treatment? Y/N If Yes, Year: _____
- Have you ever had orthodontic (braces) treatment? Y/N If Yes, Year? _____
- Have you ever had any problem with dental treatment? Y/N
  If Yes, please explain:
  _____
- Are you currently experiencing any dental pain or discomfort? Y/N
  If Yes, please explain:
  _____
- Do you have clicking / popping / discomfort in your jaw? Y/N
- Do you, or has anyone ever told you that you, clench or grind your teeth? Y/N
- Do you wear a night guard at night when you sleep? Y/N
- Do you get sores or ulcers in your mouth? Y/N
  If Yes, how often? _____
- Do you wear partials or dentures? Y/N If Yes, Do you like the way they fit? Y/N
- Date of your last dental exam: _____
- Date of your last dental x-rays: _____
- Reason for your visit today:
  _____
- Is there anything about your smile you would like to change? Y/N
  If Yes, please explain:
  _____

PATIENT SIGNATURE: _____ **DATE:** _____

MEDICAL HISTORY:

PATIENT NAME: _____ **DOB:** _____

- Are you currently under the care of a physician for reasons other than routine medical? Y/N
  If Yes, Physician's Name and Phone Number: _____
- **Are you allergic to any of the following?** (If Yes, Please circle)
  Penicillin Latex Sulfa Codeine Metals Novocain Other: _____
- Do you use tobacco? Y/N If Yes, (Please circle) Smoke / Smokeless
- **Are you currently taking any medications? Y/**N If Yes, Please provide the names of medication:
  _____
  _____
  _____
- Have you had an orthopedic joint replacement? Y/N
  If Yes, What type? _____ Date of placement: _____
- Have you had a heart valve replacement, or do you have a damaged heart valve, requiring pre-med? Y/N Date of placement: _____
- Do you have: (Please circle)
  Active Tuberculosis (TB)? Have you been exposed to anyone with TB?
  Persistent cough greater than 3 weeks? Cough that produces blood?

Please check if you have experienced ANY of the following: (Please mark ALL responses)

Abnormal Bleeding	O YES	O NO	Epilepsy	O YES	O NO
AIDS (HIV+)	O YES	O NO	High Blood Pressure	O YES	O NO
Alcohol/Drug Abuse	O YES	O NO	Kidney/Bladder Disease	O YES	O NO
Anemia	O YES	O NO	Pace Maker	O YES	O NO
Arthritis	O YES	O NO	Psychiatric Care	O YES	O NO
Asthma	O YES	O NO	Radiation Treatment	O YES	O NO
Back Problems	O YES	O NO	Rheumatic Fever	O YES	O NO
Blood Disease	O YES	O NO	Shortness of breath	O YES	O NO

Cancer	O YES	O NO	Stroke	O YES	O NO
Chemotherapy	O YES	O NO	Thyroid Problems	O YES	O NO
Cortisone/ Steroid Treatment	O YES	O NO	Tonsillitis	O YES	O NO
Depression/ Anxiety	O YES	O NO	Mitral Valve Prolapse	O YES	O NO
Dizziness	O YES	O NO	Ulcers	O YES	O NO
Headaches	O YES	O NO			
Heart Murmur	O YES	O NO	**Women ONLY:**		
Heart Problems	O YES	O NO	**Taking Hormones**	**O YES**	**O NO**
Hepatitis/ Liver Disease	O YES	O NO	**Currently on Birth Control**	**O YES**	**O NO**
Herpes/ Fever Blisters	O YES	O NO	**Currently Nursing**	**O YES**	**O NO**
Chest Pains	O YES	O NO	**Pregnant Weeks:_____**	**O YES**	**O NO**
Diabetes	O YES	O NO			
Take Aspirin/ Blood Thinners	O YES	O NO			
Taken Bisphosphates (Medication for bone strengthening)	O YES	O NO			
Taken Fosamax	O YES	O NO			

- Have you ever been hospitalized, or had any surgeries? Y/N Is there any disease or condition you have that we have not covered? Y/N
  If Yes, please explain:
  _____
  _____

PATIENT SIGNATURE: _____ **DATE:** _____

PATIENT REGISTRATION:

PATIENT NAME: _____ **DOB:** _____

Home Address: _____

Best Phone Number to reach you during Daytime/ Business Hours: _____

Number is: Home / Work / Cell / Other

E-mail Address: _____

Referred by: _____

Emergency Contact Name: _____ Phone Number: _____

Minors ONLY:

Person Financially Responsible: _____ Relationship: _____

Phone Number: _____

Do you have Dental Insurance? Y / N

Dental Insurance Company: _____ Phone Number: _____

Claims Mailing Address: _____

Subscribers Name: _____ Subscribers DOB: _____

Subscribers ID or SSN: _____ Patient Relationship to Subscriber: _____

Group Number: _____ Subscriber Employer: _____

What are your Primary Concerns for Today's Visit? (Please check all that apply)

- Routine Cleaning and Exam/ General Health
- Gum/Periodontal Disease
- Oral Cancer
- Cavities
- Broken Teeth
- Appearance
- Bad Breath
- Other: _____

PATIENT SIGNATURE: _____ **DATE:** _____