Please complete the following confidential information

1

Getting to know you Date ____________/____________20______

Patient ____ ❒ Male ❒ Female Birthdate __________
Last Name (Mr. Mrs. Miss) First Name Middle Name

Full name of husband, wife or parent if child ____

Driver's License No. ______________________________ Social Security No. ______________________

Residence Address ____ Phone ( ) ______________

City: ______________________________ Zip Code __________ E-mail ______________________

Employer ____ Occupation ______________________

Business Address ____ Phone ( ) ______________

City ____ Zip ______________________

Spouse employed by ______________________ Occupation ______________ Social Security No. ______________

City ______________________________ Zip Code ______________ Phone( ) ______________

2

Do you have dental insurance? Yes ❒ No ❒ If yes, please bring your policy book and insurance form COMPLETED.

Who may we thank for referring you? ____

Person to contact for emergency ______________________________ Phone ( ) ______________

Medical History

3

Name of Physician ______________________________ City __________ Phone ( ) ______________

Date of last medical exam ______________ Do you have a current medical problem? Yes ❒ No ❒

If yes, please state ____

Have you ever had or do you have any of the following, please check yes or no

Yes	No	
❒	❒	Hepatitis, liver disease, jaundice
❒	❒	Rheumatic fever
❒	❒	Diabetes
❒	❒	High blood pressure
❒	❒	Heart trouble: what kind ______________
❒	❒	Heart murmur
❒	❒	Shortness of breath
❒	❒	Swelling of ankles or feet
❒	❒	Stroke-When ______________
❒	❒	Blood trouble, anemia, leukemia
❒	❒	Serious accident ______________
❒	❒	Excessive bleeding requiring treatment
❒	❒	Venereal disease, social diseases
❒	❒	Lung trouble (TB, asthma, emphysema)
❒	❒	Arthritis, sore joints
❒	❒	Fainting spells, epilepsy, convulsions
❒	❒	Headaches
❒	❒	Nervous breakdown
❒	❒	X-ray, indium or cobalt treatments
❒	❒	Tumor or cancer
❒	❒	Major operation
❒	❒	Herpes virus
❒	❒	Told or tested positive for HIV
❒	❒	Allergic to Latex
❒	❒	Prosthetic joint, valvular or aesthetic treatment

Are you now:

Yes	No	
❒	❒	Pregnant-due date ______________
❒	❒	On a prescribed diet
❒	❒	Using thyroids
❒	❒	Using hormones (inc. birth control pills)

Are you now taking medicines for: (Please specify)

Yes	No	
❒	❒	Pain ______________
❒	❒	Nerves (tranquilizers) ______________
❒	❒	Sleeping ______________
❒	❒	Blood (thinners, liver, iron pills) ______________
❒	❒	Stomach trouble (ulcer, other) ______________
❒	❒	Heart ______________
❒	❒	Headaches ______________
❒	❒	Arthritis or rheumatism ______________
❒	❒	Allergy (Asthma) ______________
❒	❒	Using other medicine ______________

Have you ever been sick from, show an allergy to, or told not to take ______________________________

Yes	No	
❒	❒	Antibiotics
❒	❒	Codeine
❒	❒	Aspirin
❒	❒	Novocaine (or other dental anesthetic)
❒	❒	Other drugs or medicine (please specify)

Do you have any disease, condition, or problem you think we should know about that is not mentioned above?
If so, explain: ____

Please turn over

DENTAL HISTORY

1. Reason for this visit ______
2. Name of previous dentist ______ Date last treated: ______
3. Date of last complete series of dental x-rays ______
4. Are you having pain at this time? ____ Where: ______ Yes ☐ No ☐
5. Have you ever had:
   a. Orthodontic treatment? Braces - Year ______ Yes ☐ No ☐
   b. Oral surgery? Extractions - Year ______ Yes ☐ No ☐
   c. Periodontal treatment? Gum Treatment - Year ______ Yes ☐ No ☐
   d. Your bite adjusted? Year ______ Yes ☐ No ☐
   e. Or worn a bite plate or other appliance? Year ______ Yes ☐ No ☐
6. Have you noticed any loosening of your teeth? ______ Yes ☐ No ☐
7. Does food tend to become caught between your teeth? ______ Yes ☐ No ☐
8. Do your gums often bleed when you brush your teeth? ______ Yes ☐ No ☐
9. Problems of the jaw. Have you ever experienced:
   a. Clicking of the jaw? ______ Yes ☐ No ☐
   b. Pain (joint, ear, side of face)? ______ Yes ☐ No ☐
   c. Difficulty on opening and closing? ______ Yes ☐ No ☐
   d. Difficulty in chewing? ______ Yes ☐ No ☐
10. Habits. Do you:
   a. Clench or grind your teeth while awake or asleep? ______ Yes ☐ No ☐
   b. Bite your lip or cheeks regularly ? ______ Yes ☐ No ☐
   c. Hold foreign objects with your teeth (such as pencils, pipe, pins, nails, fingernails)? Yes ☐ No ☐
   d. Mouth breathe while awake or asleep? ______ Yes ☐ No ☐
11. Do you feel very nervous about having dental treatment? ______ Yes ☐ No ☐
12. Have you ever had an upsetting experience in the dental office? ______ Yes ☐ No ☐
13. Are you satisfied with the appearance of your teeth? ______ Yes ☐ No ☐
14. Please explain - any YES answers above: ______

______

______

______

CONSENT

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient)______
and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, and are due and payable at the time services are rendered, unless previous arrangements have been made.

Signature ______ Date ______

Relationship to Patient ______

FOR OFFICE USE ONLY

HISTORY UPDATE

Date: ______ Changes: ______ Initial: ______

Date: ______ Changes: ______ Initial: ______

Date: ______ Changes: ______ Initial: ______

Date: ______ Changes: ______ Initial: ______